health action

MOTHER AND CHILD CARE

02440

We see 6 ravellers in

We're referring to the different points of view that people have about the Tempo-Traveller.

Some view it as an airline coach for air hostesses, pilots and crew members.

Others find it a perfect bus for tours and travel.

Still others see it as the ideal vehicle for 5-star hotels.

Senior executives in leading companies want it to get to work comfortably.

As a superior ambulance, hospitals and private clinics value its intensive-care features.

Many even consider it a very private and personal vehicle.

Add it all up and you get 6 distinct Tempo-Travellers.

eller
v'd call it
ter

po LTD.
ning.

W
OM 616
extremely econom run and maintain.

Added to all this is its interior which is so luxurious, so plush that you just don o get off.

See it for yourself. You will probably find the seventh Tempo-Traveller in this picture.

Dedicated to

Photograph: Courtesy Premier Studios, Secunderabad

Nobel Laureate **Mother Teresa,**

compassionate, loving champion of mother, child and under-privileged

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad–500 003. Ph: 841610

health action

A HAFA NATIONAL MONTHLY
SPECIAL ISSUE PRICE Rs. 40/-

Printed and published by Ms Patricia Palaparti for and on behalf of Health Accessories for All (HAFA) at Pragati Art Printers, Red Hills, Hyderabad

Editorial and Administrative Offices:
HEALTH ACTION
PB 2153, 157/6 Staff Road
Gunrock Enclave, Secunderabad 500 003
Tel 848293 848457 841610

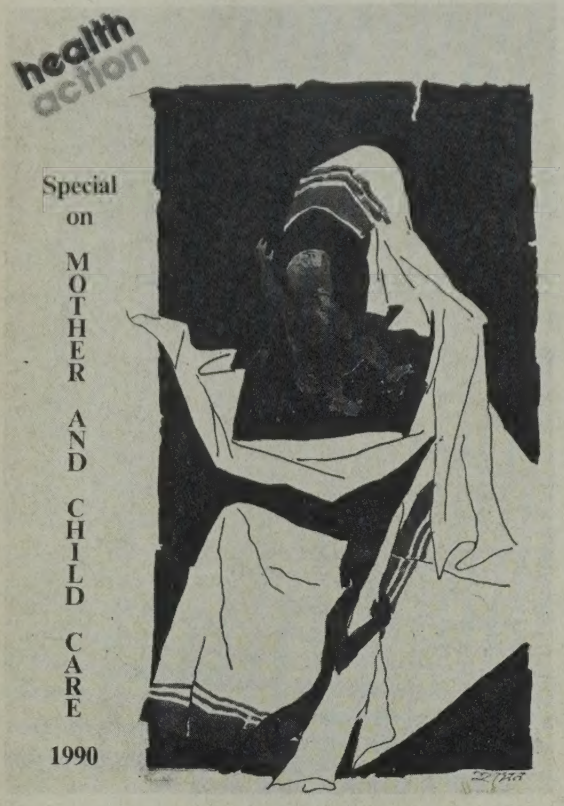
DELHI OFFICE:
CATHOLIC HOSPITAL ASSOCIATION OF INDIA
CBCI Centre, Ashok Place, Goldakhana
NEW DELHI-110 001 Tel: 310694

Subscription rates from January 1990

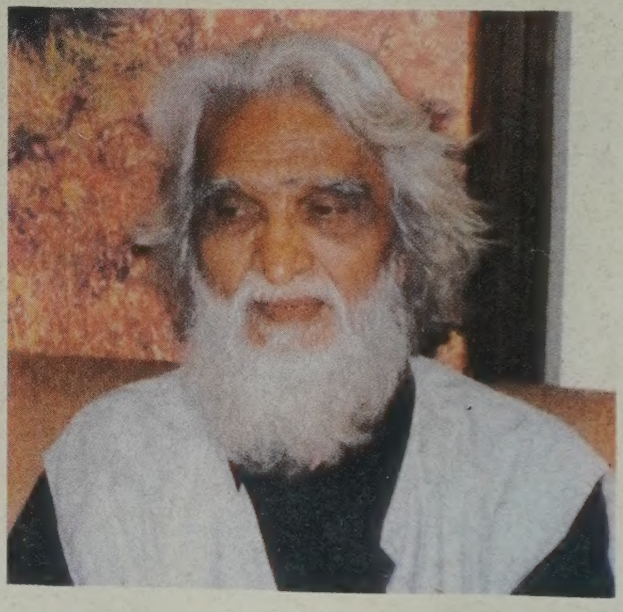
Annual Individual:	Rs 60
Annual Institution:	Rs 80
Life Membership:	Rs 1000
Foreign Annual:	US $ 50
Foreign Life:	US $ 500
Single Copy:	Rs 7

Contents

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad–500 003. Ph: 841610



Cover picture painted by
M F HUSSAIN
for the Health Action
special on
Mother and Child Care



Our grateful thanks to
Mr. M F HUSSAIN
for his invaluable
contribution to our
special issue dedicated
to the living saint,
Mother Teresa

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad–500 003. Ph: 841610

Message

I feel the greatest destroyer of peace today is abortion, because it is a direct war, a direct killing, direct murder by the mother herself. And we read in the scriptures, for God says very clearly: "Even if a mother could forget her child, I will not forget you. I have carved you in the palm of my hand." We are carved in the palm of His hand; so close to him, that unborn has been carved in the hand of God. And that is what strikes me most, the beginning of that sentence, that even if a mother ***could*** *forget — something impossible — but even if she could forget, I will not forget you.*

Our Children, we want them, we love them. Many million children are dying of malnutrition and hunger and so on, but millions are dying deliberately by the will of the mother. Let us ensure that we make every single child born and unborn, ***wanted.*** *I know of nothing sadder than the lack-lustre eyes in an unwanted child's face.*

Our Shishu Bhavan is a refuge of exceptional love for crippled and unwanted babies and children, some of whom were found in dustbins and drains or simply abandoned. Nearly all suffered from acute malnutrition and tuberculosis, all were crying out for love.

So my message to you and to all in the field of Health Care is to make each person feel wanted and loved and to care for each one always with a smile, especially when it is difficult to smile. This is where love comes in — when it is difficult and demanding — to still smile and heal both body and mind with love.

Whenever we do something for love of God, He will bless our work and all our efforts for Him — I have no doubt that this will be the case with your 'Rights of the Child' campaign and with the special issue of Health Action on 'Mother and Child Care'. Put your trust in God and He will make your work fruitful.

I assure you of my prayers and those of my Sisters too.

God bless you all
Mc Teresa

For those who will not settle for second best,
there is only one choice **YAMAHA**.

YAMAHA

RX100

A bike so unique that it has been admired and envied the world over.

Today, the **YAMAHA** remains unchallenged. And so it will be in the years to come.

RIDE THE INTERNATIONAL FAVOURITE

ESCORTS

From the Director's desk

Health is the most sought after thing in the world today by all, no matter who we are or where we are. Mother and Child Care assumes the greatest importance where health is concerned. But the question to be asked at the very outset is, how many understand its importance in any case ?

The daily experiences in our country, some of which may catch the attention of some journalists and government officials concerned, show that care of Mothers and Children is not just shamelessly neglected by all concerned, but even worse, our society sees no wrong in the way we treat our mothers and our children. Though the framers of our Constitution provided sufficient protection for women and children, they are denied these sacred rights everywhere.

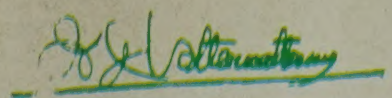
The recent turn given to the Roop Kanwar case of Deorala by interested parties, not without the knowledge of even some government people, trying to re-introduce the most cruel practice of murder in the name of "Sati", though a law against it was enacted as far back as 1882 by Lord William Bentick; or the suicide on 4th February, 1988 of the three sisters of Kanpur i.e. Poonam, Kamini and Alka to relieve their parents from dowry debts, are only notorious examples of what is happening daily in our country of Buddha and Mahatma Gandhi. That too when there are laws already existing against atrocities on women and children.

Even after 43 years of our Independence if the situation in our country allows one mother to die every six minutes and one child to die every twenty seconds and if the plight of millions of our mothers and children who manage to survive is shamelessly miserable to say the least, I would say that our leaders, government officials and all others concerned better re-think about their priorities and value systems. If these voiceless victims of our lopsided development would one day start speaking out and rise to the occasion no power will be able to hold them back.

However, the picture is not all that dark. There are, of late, some signs of hope. Thanks to the efforts of governments and voluntary organisations all over the world as also in our country, things are changing, and changing for the better. The declaration of 1990 as the SAARC Year of the Girl Child and also as the International Literacy Year by the United Nations, and an ever increasing number of governments and voluntary organisations taking up the issues connected with Mother and Child Care, are all signs of hope for the future.

Let us hope that one day this neglected and vulnerable section of society comprising the majority of our population will have a better chance of survival and the opportunity to live a healthier, fuller life in dignity and self-respect.

The Catholic Hospital Association of India (CHAI) with its nearly 2,500 member institutions most of which are situated in the remote rural areas of this vast country and Health Action our National monthly magazine, attempt to contribute to the best of our ability, our share towards the fulfilment of this gigantic task.



Fr John Vattamattom svd
Executive Director — CHAI
Managing Director — HAFA

Editor speaks —

Time is running short to achieve the targets set by us towards Health for All. These targets are moderate and attainable. They are within our reach, provided we have the will and work with the realization that health is an integral part of overall development.

One of the most important requisites of health is the care of the mother and child. Positive programmes towards promotion of the health of these vulnerable groups of expectant mothers and children are required. The programmes must include health education, nutrition and those promoting physical, mental, social and spiritual development. Literacy, living wages, marriage at the proper age and a stable family contribute a great deal towards health.

A few simple steps in the care of the mother and child can save millions of lives and reduce disease and disability and life-long misery.

An important step is to make child-bearing devoid of dangers. Good pre-natal care and care during child birth and thereafter can make the family healthy and happy. An expectant mother requires plenty of food and rest. Working women need special care.

Primary ante-natal care must reach out to all pregnant women. It is also necessary tc ensure that help is available to all those who need it at the time of delivery. Child bearing and child birth are normal events in the life of the woman. Where there are abnormalities, assistance is required.

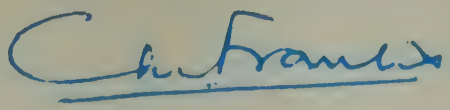
Drugs are not usually required during pregnancy. In fact, all drugs must be avoided, except where absolutely indicated. One common feature is a mild anaemia. This can be got over by simple iron tablets. Fancy tonics and other drugs should not be taken.

Care of the newborn is important. Breast milk provides the best possible food. Almost all mothers have enough milk. Breast feeding reduces the incidence of common childhood illnesses. Upto 4 to 5 months, breast milk alone is sufficient. After that, breast feeding must be supplemented. Breast feeding can be continued upto 18 to 24 months, together with other foods.

One of the major common illnesses of childhood is diarrhoea. The adverse effects are mainly due to dehydration. It can be prevented by taking fluids. Any type of fluids —breast milk, rice water, gruel and soups — can be given. Oral rehydration solutions are helpful to counter dehydration and replace the lost fluid and salt and give energy.

The Universal Immunization Programme is now being implemented with vigour. The body defences can be built up against these major killers. People are already talking about making poliomyelitis and the disabilities arising therefrom a matter of history.

There are many other steps to be taken to improve the health of the mother and child. It is not enough to avoid death and disease. The child needs to develop physically, emotionally, socially and spiritually. All these must be provided with loving care.

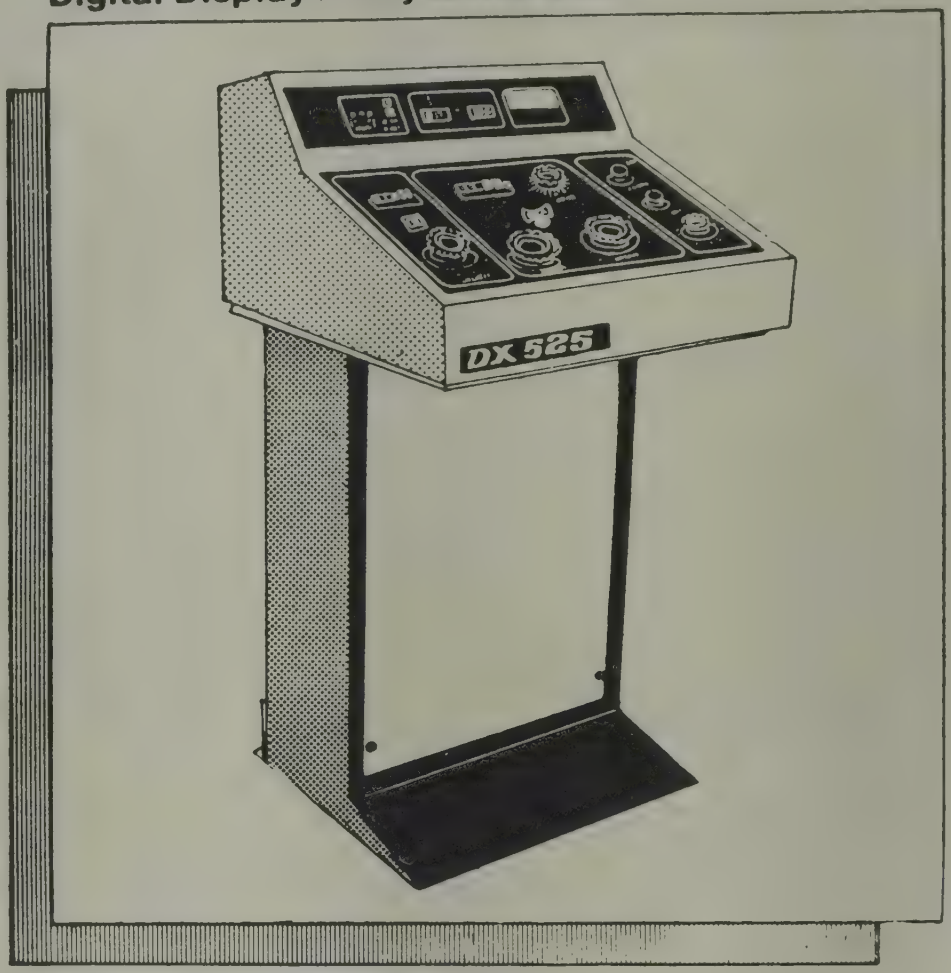


Dr C M Francis

The forerunner in the series of new generation X-Ray Diagnostic Units ...

A fusion of economy and technical excellence

DX-525 500mA-125 KVP
Digital Display X-Ray Generator



For details on the above and complete range of X-Ray equipment from portable 20 mA to 1000mA, full-wave rectified, 3-phase 12 pulse configuration.

Contact:

I G E (India) Ltd.

'Nirmal' Nariman Point, Bombay 400 021

Branches at. Ahmedabad. Bangalore. Bhopal. Calcutta. Chandigarh. Chinchwad. Delhi. Ernakulam. Hubli. Jaipur. Lucknow. Madras. Meerut. Patna. Pune. Rajkot. Secunderabad. Trivandrum.

Mother and Child

Dr C M Francis

Present Scenario

The well-being of the mother and child determines the present health of the family and the community and the future health of the population. The health of these vulnerable sections of the community needs special attention. Unfortunately we have not done so; hence, we are paying the price of high infant and maternal mortality rates and avoidable diseases and disabilities.

Infant mortality rate

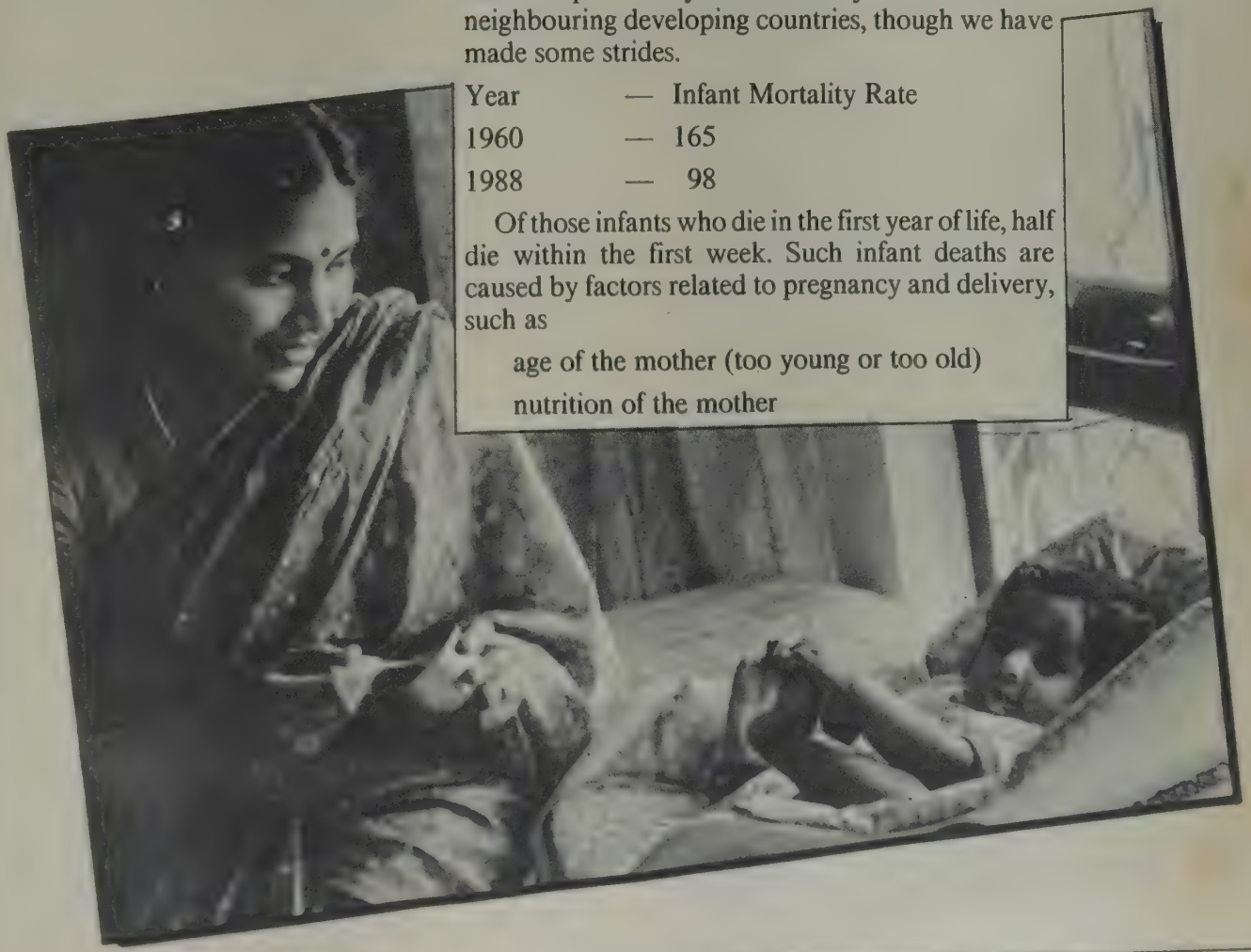
Though a negative index of health, it is a sensitive one. The infant mortality rate is very high in India and compares very unfavourably with even our neighbouring developing countries, though we have made some strides.

Year	—	Infant Mortality Rate
1960	—	165
1988	—	98

Of those infants who die in the first year of life, half die within the first week. Such infant deaths are caused by factors related to pregnancy and delivery, such as

age of the mother (too young or too old)

nutrition of the mother



care during pregnancy (antenatal)

care during delivery and immediately thereafter, and

economic and cultural factors.

Many of these factors tend to reduce the birth weight of the new born. Babies with low birth weight have a 3-4 times greater likelihood of dying than babies with normal birth weights.

Percentage of children with low birth weights: 30% (1982-88)

Unhygienic conditions and habits at birth add to the problem; neonatal tetanus is a common cause.

Neonatal tetanus can be brought under control by immunization of the mother against tetanus. Some achievements has been made:

Year	— Pregnant Women: Immunization against tetanus
1981	— 24%
1988	— 58%

Under-5 Mortality rate

Another sensitive indicator of health which is being used more and more is the under-5 mortality rate. This again is unacceptably high in India, though some progress has been made.

Year	— Under-5 mortality rate
1960	— 282
1988	— 149

Children die because of many causes; most of them are preventable. An important factor is breast-feeding. Breast feeding was well-accepted in India. But with more and more women taking up work outside the home and other influences, this habit is less now. Breast-feeding can reduce illness and death.

Growth monitoring can give indications of the health of the child. If the child does not show gain in weight for two consecutive months, there is cause for alarm.

Control of diarrhoeal diseases and especially of dehydration are now possible. So also the major killer diseases of childhood can be controlled by the universal immunization programme, if carried out diligently. There has been a drive for immunization and the percentage of children covered has increased:

Disease	Year 1981	Year 1988
T.B.	12%	72%
DPT	31%	73%
Polio	7%	64%
Measles	—	44%

Safe Drinking Water

An important requirement for health is the availability of sufficient water of good drinking quality. It must be available within a short distance from the home.

Percentage of population with access to safe water (1985–87)

Urban	—	76%
Rural	—	50%

Sanitary disposal of waste

Most parts of the country do not have adequate sanitary facilities or methods of disposal of waste. These lead to water borne and water related diseases and also to the breeding of mosquitoes and flies which transmit germs and cause disease.

Personnel

There has been increase in the number of health personnel. The emphasis earlier had been on the training of doctors and other paramedicals, suited to the hospitals and larger countries. In more recent times, the emphasis shifted to the peripheral areas. As on 31.3.1988 we had

5,58,919 trained dais,

3,92,344 village health guides, and

1,92,586 multipurpose workers (male and female)

The institutional support in the periphery (rural) has also increased with

1,09,644 subcentres

16,449 primary health centres, and

1,293 community health centres

Programmes

A number of national programmes of control of infections and diseases have been initiated and are currently functioning. Programmes to meet deficiency diseases are also available.

Vitamin A deficiency

Realising the importance of Vit. A deficiency in the causation of childhood blindness and also in aggravating childhood infections, a programme of supplementing with Vit. A has been taken up.

Iodine deficiency

Universal iodisation of salt has been taken to prevent diseases caused by iodine deficiency-endemic cretinism, deaf-mutism, mental retardation and foetal hypothyroidism. This programme has met with some resistance in implementing.

Iron deficiency

Many pregnant women have nutritional and iron deficiency anaemia. They are given iron with folic acid to correct the anaemia

Integrated Child Development Scheme (ICDS)

On October 2, 1975 (Gandhi Jayanthi Day) was started the Integrated Child Development Scheme. Originally, there were 33 projects, which were expanded to 1356 in ten year's time. The programme covers 1189 community development blocks and 157 urban slums (1988). There were great expectations. The beneficiaries are pregnant and nursing mothers and children of the age group, 0–6 years. ICDS is a network of anganwadis. Local women are selected and given short periods of training and also continuing education.

The ICDS programme includes:

supplementary nutrition,

immunization,

health check-up,

nutrition and health education to women,

treatment of minor illnesses and referral services,

preschool and non-formal education, and

other supportive services.

Life expectancy

Among the sum-total effects of better health is increase in life expectancy at birth. This has gone up, though it is still much below the life expectancy in the affluent countries.

Year	Life expectancy at birth
1960	44 years
1988	58 years

Health and Development

Health is a part of total development and contributes to it. Health depends on progress in other areas such as literacy, employment, income, agriculture and other factors. Among them one of the most important factors is literacy and education.

Literacy

Adult literacy rate: There has been very little overall progress. Female literacy has lagged far behind.

Year	Literacy %	
	Male	Female
1970	47	20
1985	47	29

With the increase in population, the above figures would indicate that the number of illiterates has actually increased.

The primary school enrolment (PSE) has shown an increase:

Year	PSE ratio (gross)	
	Male	Female
1960	80	40
1986–88	100 81	81

Though the statistics show an increase in enrollment, the fact remains that many children are outside school. Drop-outs are common.

Secondary school enrolment also has shown some increase:

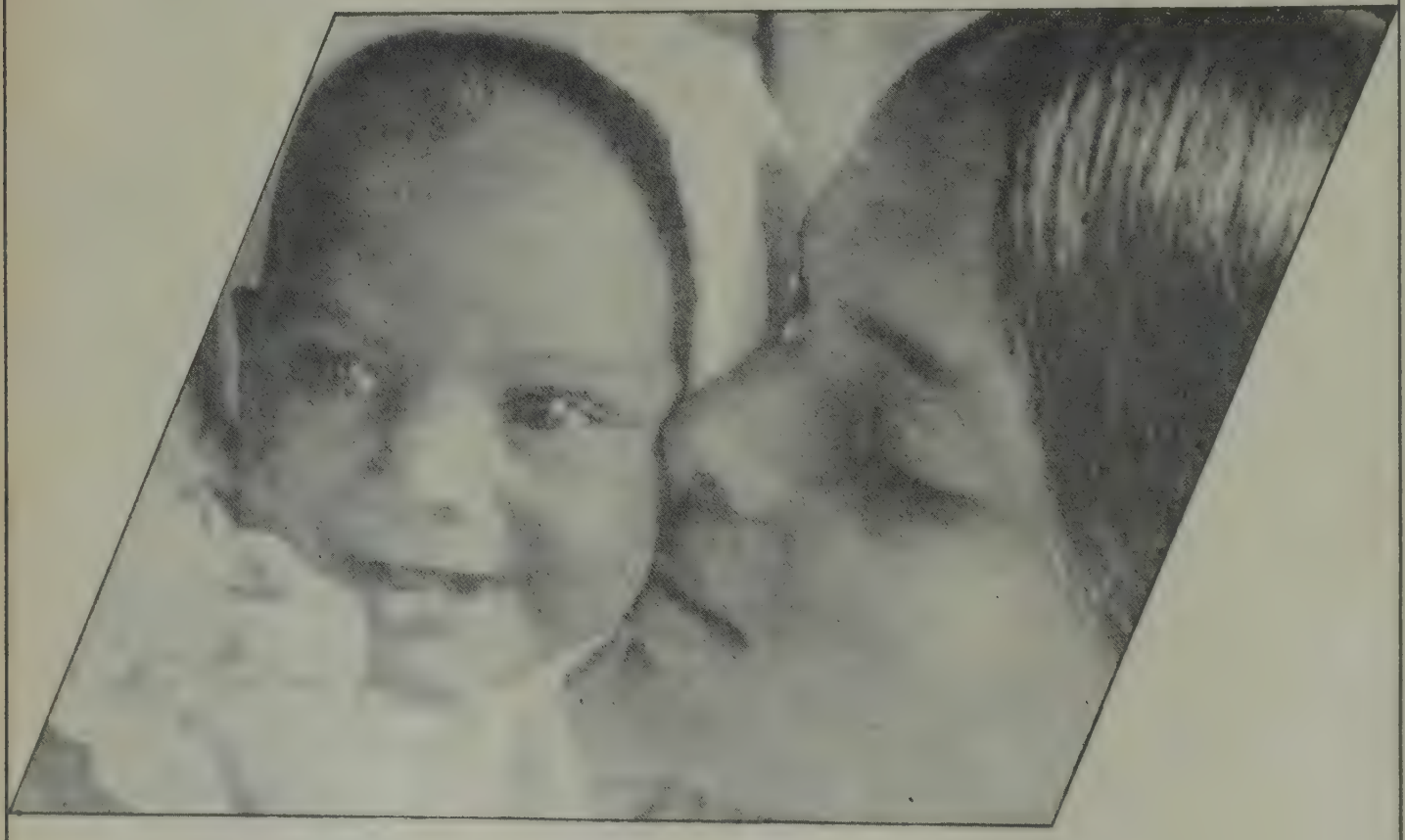
1986-88	Male:	50%
	Female:	27%

The gender disparity is very evident.

Income

The Gross National Product per capita is about Rs. 5,000/- (1987). This is an average and hides the huge disparities in income. There are large numbers of families living below the absolute poverty line.

Year	Those below absolute poverty line
1977-1987	Urban : 40
	Rural : 51



Who dies when and from what — and why isn't more being done about that ?

Opportunities for Meeting the Challenges of Child and Maternal Mortality in India in the 1990s*

Rolf C Carriere
UNICEF, New Delhi

Many of the most pressing issues in reducing maternal and child mortality, morbidity, disability and malnutrition are no longer merely medical or technical, but require broad-based, multi-disciplinary approaches for their solution.

I will begin by repeating some shocking statistics about India's performance in child and maternal survival which, compare to most other low-income countries, continues to lag. Then I will explore the reasons for the irrationally long lead-time before society fully applies and benefits from the available primary health care technologies even when these technologies are entirely effective, very well affordable and eminently beneficial. Thereafter, I shall propose a few lines of action which, I believe, would accelerate the application and utilisation of these technologies. And, finally, I will compare the tremendous benefits of success with the even higher cost of failure.

From the title of this oration: "Who dies when and from what — and Why isn't More Being Done about That" you may discern a sense of impatience, bordering on frustration, about the slow progress and the lack of more or better results. But the subtitle "Opportunities for Meeting the Challenges of Child and Maternal Mortality in India in the 1990s" reflects at the same time a sense of hope, of expectation and excitement about the incredible opportunities right in front of us. For, while we can all see the many missed opportunities and avoidable delays of the recent past, I do believe that we now have the beginnings of a quiet health revolution

* Adapted from Dr. B.L. Kapur Oration-1989

Dr. B.L. Kapur Oration which is being held every year in the memory of late Dr. B.L. Kapur, the Founder Secretary of Indian Hospital Association.

underway in many of the rural areas, the start of what can become a veritable transformation in this society's health and nutrition condition, especially of its weakest, most vulnerable and most numerous members — with potentially far-reaching consequences for fertility regulation, productivity, resilience, self-image and influence.

But the fact that immediate and dramatic improvements in maternal and child survival chances, and in healthy child growth, can now happen does not automatically mean that it will happen. What does it take to translate that possibility into reality? The single most important ingredient, in my opinion, is visionary, persistent and pragmatic leadership to create ever widening circles of commitment to this cause. Leadership by whom ? I will be back to this question later.

Rule of Halves

Let us take the first question first: Who dies ? The answer is obvious: we all do — eventually ? The mortality rate has always been, still is, and in all probability will continue to be one per person! But there are significant differences around the world in when people die. The most glaring disparity is that while people in high-income countries die, overwhelmingly, in late adulthood, of old age, long, long after childhood, in the low-income countries death has a very strong preference for the young, the very young. Mortality here has an age-bias towards the beginning of life outside the womb. The curve showing the relative risk of dying over a life-time in the industrialised world is slowly sloping upwards, with a sudden steep incline around 60 years, somewhat like a boomerang, while for the developing world it looks more like a U-shape. Please note that these graphs from the age of 5 onwards, are almost identical, since the survival chances after five in the developing and high-income countries are pretty much the same.

Their principal difference, in relation to survival, lies in the first five years of life. Death in the developing world strikes proportionately more frequently among this age group. And the younger — and thus the more vulnerable — the child, the higher the chances of premature mortality. For ease of memory, let me present a mnemonic which I shall call the ROHDE RULE OF HALVES, after its articulator, Dr. Jon Rohde.

This rule, which by and large applies to all low-income countries, goes as follows:

—of all those who die in a year, half are children under five (although they account for only about 15 percent of the total population!);

—of all those under-fives who die each year, half are infants under one year;

—of all infants who die every year, roughly half die before completing their first month of life;

—of all these neonates who die before reaching the end of the first month of their life, again half do not live longer than one week;

—and, finally, of all those who die in the first week after birth, half die on their day of birth.

Thus, for too many of the young in the developing world, there is no life before death. There is only death before life! The implications of Rohde's Rule of Halves for health and nutrition planning and programming, and especially for the selection of priority target age-groups, are profound. Any policy aimed at maximum mortality control, any serious efforts to maximally reduce preventable death must focus its attention and resources on the youngest children, especially of neonate and infant age — and, of course, on fertility regulation, to reduce the absolute number of births from which those deaths result in the first place! I will come back to one other of the interrelationships between maximum mortality and fertility control, later on in this presentation.

India's Best-kept Secret ?

The question may well be asked: how does India compare with other developing countries in reducing preventable mortality ? What is India's share in the developing world's burden of illness, disability and death ? Now here we are in for some startling surprises. For, naturally, one would expect India's performance to be well above-average, given its remarkable achievements, over the past four decades, in the fields of communication and industrialization, space exploration and nuclear energy, food production, famine prevention and disaster management.

Yet, upon closer scrutiny, the picture that emerges with regard to child and maternal survival in India is by no means complimentary. India is one of the laggards of the developing world when it comes to maternal and child survival. In fact, it ranks among the worst in the developing world.

Let's review the facts.

No country sees more mothers die each year because of child-bearing causes than India does. In absolute numbers — over 125,000 Indian mothers die each year from pregnancy related causes, leaving behind 250,000 motherless children.

No country sees more children die or become disabled each year from readily preventable common illnesses than India does.

These two stark facts cannot be explained away by a mere reference to India's population size.

Statistics reveal that India's share in maternal mortality and child morbidity, disability and mortality is disproportionately high compared with the rest of the developing world.

For example, although India's population is only 21 percent of the developing world's population, it accounts for at least 25 percent — and perhaps as much as 30 percent — of the developing world's maternal deaths.

Likewise, death from measles (39% of the developing worlds total), diarrhoea (33%), tetanus (31%), pertussis (41%), and polio lameness (44%), show that India has a much larger share of the developing world's disease and death burden than would be expected on the basis of its population size. Similarly, whereas in the developing world as a whole 17 percent of newborn babies have low birth-weight — an accurate predictor of risk of dying — the corresponding percentage for India is almost twice as high!

This may well be India's best-kept secret. These facts are not as well recognized as they should be, here or elsewhere. It is amazing, actually, that these facts have not become the target of intense scrutiny.

To be sure, these statistics refer to mid-decade, and some important progress has been made since 1985 in reducing the absolute number of deaths, especially vaccine — preventable deaths and disability. But the proportions cited here remain essentially the same — and some have actually deteriorated further since then, reflecting faster acceleration and greater success which other developing countries have achieved in their child survival and safe motherhood programmes.

What would explain this unexpected performance? Why has not more progress been made ? What has gone wrong ? What is missing ?

Three Wrong Notions

I do not claim to have the answers to these questions, but I would venture to outline some promising approaches that might help accelerate, broaden and deepen the potential health revolution I spoke of earlier. Before doing so, however, I would like to dispel three wrong notions.

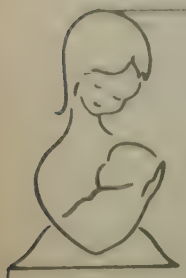
No Solutions ?

First, it is incorrect to think that we do not now possess a decisively effective health technology for prevention or cure of the leading causes of maternal and child deaths and disease. I do not need to elaborate, for this audience, what those major causes are, except perhaps to repeat that more than half of the cases of deaths among infants and young children is attributable to a mere handful of causes — such as prematurity and delivery trauma, tetanus, respiratory ailments, diarrhoeal diseases, measles, other infections such as malaria and typhoid — most often with repeated growth interruptions and malnutrition as an underlying or associated factor. These are not exactly exotic causes requiring sophisticated remedies.

Likewise, the majority of maternal deaths are due to a few conditions only, such as anaemia and malnutrition, improper birth spacing and timing, and common complications of pregnancy.

For all these conditions — and for others — appropriate primary health care technologies are now available that make these deaths and diseases, at any rate most of them, completely avoidable.

The child survival package of health technologies includes, at a minimum, immunization, oral rehydration and proper diarrhoea management, pneumonia therapy, nutrient supplementation and



fortification (such as iodine, iron and vitamin A, improved infant feeding practices, and a practical concern for growth promotion.

The safe motherhood programme would at least include the following components: therapeutic iron supplementation, improved maternal nutrition, better birth spacing and proper antenatal and birthing care, tetanus and a package of transferable knowledge about safe motherhood.

The credit for making this feasible goes to the medical community, for its break through scientific work over the past few decades. As a result, today, a solid scientific consensus stands behind a body of knowledge and interventions, sound in practice as well as theory, traditional as well as modern, invented or discovered, which could enable most families and frontline health workers to prevent and treat most of the major causes of child and maternal death and malnutrition-by methods which they can understand, and at a cost which they can afford.

Waiting for Development ?

Second, it is incorrect to think that significant improvements in the lives of children and mothers — and consequent reductions in the IMR and MMR — depend primarily on accelerated economic development. In fact, there is no need to wait for economic development before we can be successful in turning the bleak statistics into positive trends. Moreover, there is nothing either rapid or automatic about the conversion of economic progress into tangible survival and health benefits for the poorest children and their families — as the development patterns of several Middle-Eastern countries show. Whilst recognising the potentially important contribution of economic growth to the lives of children and mothers — and it is good to remember that India has thus far largely escaped the fate of economic recession and an unmanageable debt burden that face many other developing countries, but that could take a turn for the worse nonetheless, the means are now at hand — and entirely affordable — to make the protection of the lives of mothers and children, and their healthy mental and physical growth into a cause as well as a consequence of economic advance. For we believe that there is a profound connection between the growth of the body and the mind in childhood and the growth of economies and the progress of nations. In short, good health is good economics — and good politics for Governments!

Inadequate Infrastructure?

Third, it is not correct to think that we first need more hospitals or health centres, and more doctors, nurses or multipurpose health workers, before we can succeed in effecting dramatic improvements in child survival, or safer motherhood. Unlike many African countries, India has over the past four decades, built up an impressive formal health infrastructure which is fully capable of delivering what is needed and wanted. What has been lacking, though, is a clear set of priorities, to do first things first, a careful selectivity and phasing of measures that will reap — and sustain — the greatest public health benefits in the shortest possible time. Instead, programme planners have often been unrealistic, overloading the frontline workers with far more tasks than could be done, or done well, leaving it to the discretion of these workers to pick and choose tasks, to suit their own personal preferences and predilections. Sometimes this was done under the guise of the need for holistic health delivery, or against so-called verticality. Not seldom has everything that needs doing been listed without priority ranking or agreed-upon strategies for doable, step-by-step implementation. That is one reason why so many well-intentioned plans — and so much of the knowledge and health technology — have remained on the shelf of the unrealised potential. And failure to implement has often been unfairly lamented as a lack of political will.

Don't take me wrong: I am not saying that there are no other deficiencies or constraints in the health delivery system or its management that require continuous diagnosis and remedy. Clearly, the quality of care — and caring — in the government health system leaves much to be desired and there is an urgent need to transform the provider — patient relationship from the impersonal, bureaucratised medical encounter that it now often is, into an intimate, compassionate human interaction that encourages, reassures and heals. It is this quality of caring which, I believe, makes many rural families turn to (and pay for) private medical help in

preference to the free health care offered by the government system.

But the bottom line is clearly that India's primary health care system, together with its built-in referral services, is essentially in place, ubiquitous in fact, and ready to be mobilized to make the kind of major public health contributions about which it can truly be proud. The same health delivery system which over a decade ago eradicated smallpox is, today, inherently capable of performing much more complex and demanding tasks, and achieving the far more ambitious goals set for the 1990's. That is, provided an assertive and competent public health leadership steps forward to nudge it in the right direction, with vision, pragmatism and persistency.

Going Universal with Immunization

The recent experience which the Universal Immunization Programme represents an instructive example. Once its tremendous life-sparing and disease-preventing potential and its highly favourable cost-effectiveness were fully recognised, high-level policy commitment, combined with determined public health leadership began systematically to mobilize the existing infrastructure and available manpower in a carefully phased programme expansion aimed at universal coverage within 5 years — and indefinitely thereafter. Immunization services were more sharply focused on infants, to ensure full protection before their first birthday. To improve the 6 "M"s on the supply side — Materials, Manpower, Motivation, Management, Monitoring and Money — marginal, but timely and crucial extra resources were provided. Simultaneously, a beginning was made to create, or further stimulate, demand for these immunization services by professionalising the communications efforts — the three "M"s on the demand side, namely Messages, Media and Marketing.

The result has been a doubling of coverage in less than 3 years time (to around 50% of all infants, and almost 60% of pregnant mothers). Put differently, the total immunization effort last year has averted almost half a million deaths, and prevented at least 25 million episodes of illness and about 100,000 cases of paralytic polio — a truly remarkable achievement! Nonetheless, the hardest part is yet to come: that is, to reach the other half, and to protect them as well, year after year.

Application Gap

While the immunization programme has caught the imagination of policy makers, planners and public health leaders, many of the other health technologies for child survival and safe motherhood remain without effective advocates or influential social constituencies.

In a sense, long intervals between discovery and application of new health and nutrition technology are nothing new. Think, for example, about Jenner's small-pox vaccine. This vaccine took more than 170 years before it was fully applied, and world-wide eradication of the dreaded disease was achieved. It also took an unprecedented effort in visionary, pragmatic and persistent international public health leaderships to bring this feat about.

Or take iodated salt. Goitre, cretinism and mental subnormality have long been known to be entirely preventable by fortifying common salt with iodine and consuming it, at a cost of less than a cup of tea per person per year! In fact, the discoverer of this simple technology, David Marine, 70 years ago wrote that "Simple goitre is the easiest of all known diseases to prevent. It may be excluded from the list of human diseases as soon as society determines to make this effort". Yet, decisive success in conquering this age-old scourge remains elusive, and in the year 1989 the number of sufferers from Iodine Deficiency Disorders — the single largest cause of mental disability — is on the increase in many countries! Is this low cost but highly effective technology not exciting or glamorous enough ?

Oral rehydration therapy, discovered in 1967 simultaneously in Dhaka and Calcutta, a truly universal remedy against cholera and all other types of dehydrating diarrhoeas, is yet another example. This discovery, which The Lance has described as 'potentially important medical breakthrough of the 20th century', still awaits widespread application to save the 4.5 million lives it takes in the developing world each year — no less than 4,000 every day in India! This life-saving therapy is nothing more than salt, sugar and water, given in the right proportions at the first sign of a child's diarrhoea. These ingredients are available in virtually each and every home; it is

only the awareness that is not! One could rightly ask: what is the problem with the solution ? Is it to simple?

What is even more astonishing is that around 1500 B.C, Sushruta, the father of Ayurveda, prescribed that cholera victims are to be "given to drink a profuse quantity of tepid water in which rock salt and molasses have been dissolved: or clarified water combined with rice gruel". This text (Sushruta Samhita III, Verse II) betrays an extraordinary insight into the need for fluid replacement and the apparent efficacy of the linked use of salt and sugar, thereby anticipating, by three-and-a-half millenia, the scientific validation of this practical experiential wisdom. But the question remains: how did this culture come to forget this life-saving remedy ?

These are only a few of the many disquieting examples of societal apathy, amnesia and irrationality. The list of available technologies and therapies, products and practices awaiting widespread application, dissemination and utilization runs longer, and includes a whole range of new vaccines, fortified foods and nutrient supplements, antibiotics and contraceptives, sterile delivery kits and self-health behaviours.

Social Apathy

There are many reasons for this application gap. At the level of political leaders, the prevailing perception is that there is not much to be gained, politically or economically, from the prevention of child mortality or malnutrition control. Good health for young children (who, after all, do not voice their agony or vote) has little political appeal. Moreover, most deaths, illness episodes and disability occurs in the silence of the rural villages and urban slums, far away from the vocal centres of power, unseen and unperceived by the unconcerned and unaware.

Sometimes the market forces are not conducive to the application as, for example, when there are no vested commercial interests in manufacturing or promoting the healthful product or practice, or when profit margins are low. At other times, erstwhile wholesome health behaviours are deliberately undermined, such as in the case when breastfeeding is replaced by socalled breastmilk substitutes.

Among medical professionals, it often seems that developing newer therapies and more sophisticated technologies hold greater attraction than applying the ones that we already have. Look, for example, at the current preoccupation with AIDS (which, in India to date has claimed less than a hundred lives), while in this country each day more than 4000 young children needlessly die from diarrhoea simply because parents do not know how to put the life-saving solution of salt, sugar and water together, or where to go and get a Rs. 3/- sachet of ORS. One wonders: even if, today, we had an effective AIDS therapy available — would we apply it?

In this context it is sad that many doctors, to this day, remain unconvinced about the efficacy of oral rehydration therapy. Others are just not interested in sharing this life-saving know-how with lay people. One doctor in Indonesia, several years ago, told me that he was against teaching oral rehydration therapy to mothers because, after all (as he put it) "diarrhoea is our bread and butter". What this doctor forgot (apart from medical ethics) was the original meaning of his title "doctor"!

Social Communication

During the past few years many valuable lessons have been learnt, mainly from the global immunization efforts, that have relevance for the early application of the other health technologies, and the scaling up of other priority health programmes. Let me single out two: (i) social communication, and (ii) social mobilization.

Scaling up to universal coverage levels, and then sustaining those levels indefinitely, can only be successful if a programme becomes a living societal concern.

Considering the crucial role human behaviour plays in both the supply of health services and in the demand for these services, the gap in our knowledge is, indeed shocking. Health and nutrition education programmes have almost always been based on uninspected assumptions and unverified beliefs of so-called experts. And they have been promoted with an arrogance of ignorance. That is why most health and nutrition education programmes to date have failed. We in UNICEF share in that blame.

The key to efficient and effective behaviour change and value shifts lies in a better understanding of the range, nature, prevalence and depth of existing

behaviours, perceptions, values, knowledge, resistance points, fears, incentives and motivations.

Therefore, we require behavioural information that is hard, empirical, scientifically gathered and generalizable. Recent large-scale KAP studies on diarrhoea management, immunization and leprosy have convinced us of their utility, indeed, their indispensability in shaping (or restructuring) programme strategies, in avoiding wasteful expenditures on ineffective health education, and in measuring changes in health behaviour over time. Such studies, while introducing a people's orientation and a consumer's focus also make possible as professional approach to communication, and creative message design, and a skillful use of the many mass media and person-to-person channels now at our disposal.

All these are areas of medical expertise. But unless an enlightened public health leadeship invites and mobilizes the market and audience researchers, the message designers, and the media planners, our approaches at behaviour change will remain fragmentary ineffective and amateurish. The real need is to demystify health knowledge in communication-effective ways, and for all elements of society (not just the medical profession alone) to take responsibility for the promotion of human health and well being.

The relationship between knowledge and behaviour is often complex. And the power of promoting health knowledge is a power often circumscribed by poverty, dimmed by lack of education, frustrated by the unequal status of women and limited by the lack of available physical prerequisites and supplies. Nonetheless, the spread of knowledge is a necessary preconditon for change in behaviour, and can also help to create informed community demand for the provision of basic services. In consequence, it can help people themselves to gain more confidence in their own ability, and more control over their own lives.

Family Knowledge

There is, today a greater gap than ever before in history between what has been discovered and what is known to health professionals and what is being made known to parents, between what could be done and what is being done.

Putting that body of information at the disposal of all families is a task as enormous as the rewards it offers. It is the great health challenge of our times. And to meet that challenge, it will be necessary to forge a new Public health alliance, to stimulate a new and permanent mobilisation of a wide range of conventional and unconventional resources in the cause of health. WHO, UNESCO and UNICEF have jointly, published a booklet called Facts for Life which brings together, for the first time:

★ knowledge on which there is now a world-wide scientific consensus;

★ knowledege which most parents can act on;

★ knowledge which has the potential to drastically reduce child deaths and child;

★ knowledge, therefore, to which every family now has a right;

Facts for Life is not merely to inform. Facts for Life is meant to inspire and support you, and others, in answering the question "What can I do ?", and to act on your answer. It is meant to empower you to create commitment!

Social Mobilisation

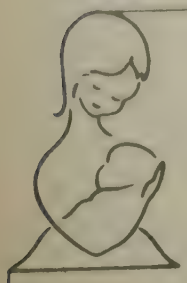
Organized social resources in India have reached the level of development at which it is possible to inform and support the great majority of families to take advantage of today's knowledge. But that new capacity has to be consciously mobilised.

It requires:

★ disseminating life-saving know-how to illiterate parents living in some 150 million households in rural villages and urban slums;

★ motivating and extending many new skills to over one million front-line health workers across the land;

★ communicating up-to-date medical information to some 500,000 private practitioners;



★ confronting and converting professional monopolisation, arrogance and pride into sharing, caring and empowering;

The social mobilization of hospitals to support primary health care, and to actively practice primary health care would include:

★ by agressively promoting voluntarily compliance to the Code on Marketing of Breastmilk Substitutes, including rooming-in, colostrum feeding and banning bottles.

★ by establishing ORT corners in all facilities;

★ by screening all patient-contacts to ensure that no eligible infant or mother would leave the hospital unimmunised;

★ providing growth charts to monitor weight changes of young children and mothers, and to counsel mothers about their weaning implications for action;

★ offering birth spacing services to all eligible couples visiting the hospital; and by making delivery rooms more hospitable places to welcome newborns into this world.

Social mobilization also requires changing the public's perception about preventive health services;

★ social marketing of life-saving and health-enhancing products and practices;

★ and, lastly, advocating and forging alliances among many diverse social partners in the corporate, public and voluntary sectors.

Who can plan, orchestrate and lead these massive social mobilization efforts ? I believe it can only be done by people like you. What is needed is your enligtened advocacy for increased resource allocation to strengthen the primary care and referral services. As the Eighth Five Year Plan is being formulated, NOW is the time, the opportunity and the responsibility to influence that planning process in the right direction. The challenge of restoring medical leadership to future health in India is an urgent and worthy one. And this public health leadership MUST come — can ONLY come — from YOU! Only you can invite and mobilize potential partners and specialists of other disciplines who are all needed in our fight for safer motherhood and better child survival. To you, leaders of the health opinion, I would ask:

If not YOU, WHO ?

If not NOW, WHEN ?

If not HERE, WHERE ?

High Price of Failure

Now we could ask the question: What if we are not going to succeed ? What would be the consquences of failure ?

During the final decade of this century, till the turn of the millennium, some 250 million children will be born in India. If current mortality rates persist, a total of about 40 million of them will not live to see their fifth birthday. Have you ever experienced how long it takes to count even to one million ?

Our failure to stem this persistent extinction of young children — when we have the means to end it — would invalidate all our other ambitions, goals and actions. A daily toll of 9,000 young Indian children throughout the next decade would not be tolerable. Likewise, if maternal death rates continue unabated, over one million Indian mothers would die in the 10 years ahead. For a world that has mastered the medical means of virtually eliminating such a carnage, this would, indeed, represent an unparalleled failure of humanity.

So, the first consequence of failure would be a major moral blow.

Another consequence would be deferred fertility reduction, recognizing the inter relationship between child survival and acceptance of family planning. Instead of reaching zero population growth rate by the year 2050, stabilizing a population of around 1300 million — which is India's current long-term goal — the population would stabilize much later, and at a higher level, possibly at 1500 or 1700 million.

A third consequence would be loss of face with the public who, rightly, has high expectations. Letting the people down may have far-reaching repercussions of its own. I shudder to visualise the consequence of that to a peaceful social order.

Making it happen

It is my personal conviction that we are entering a new age with a new ethic, an age in which all of us are

invited to personally participate in the process of growth and maturing of a planetary society, and to begin to approach old problems in new ways. The greatest single obstacle to the resolution of great problems in the past was thinking they could not be solved. The American poet Robert Frost put it this way "Something we were witholding made us weak, until we found it was ourselves". Now that we know, profoundly, that it is our very own way of thinking, looking, seeing and perceiving that makes us either part of the problem or part of the solution — and that we have a say in that matter! — we can decide for ourselves how we are going to spend the remaining 4400 days that separate us from the turn of the millennium. There is no doubt: we can do better, and we must!

As health professionals, it is our opportunity, and privilege, to help initiate and accelerate, broaden and deepen, progress in maternal and child survival which, in turn, lends hope, momentum and significance to progress in the realm of human survival. Our response-ability has never been greater. Nor has our responsibility.

As we enter the last decade of this century in fact of this millennium, what greater challenge could we spend ourselves on than to guarantee the survival and healthy growth of our mothers and children by doing the possible NOW!

With regard to that future, there are three types of people:

— Those who MAKE it happen

— Those who LET it happen

— And those who WONDER what happened.

It is up to each of us to choose.

Mother & Baby Care

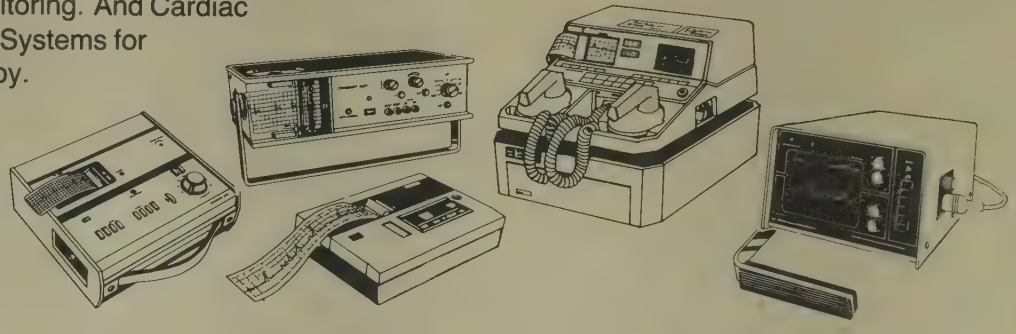
Those split-second, life and death decisions...

BPL backs them with life-saving reliability.

BPL offer cardiologists and physicians a comprehensive range of coronary care equipment. The Cardiart® range of ECGs for ***accurate*** diagnosis. Bedside Monitors for ***constant*** surveil-lance. Central Nursing Stations for ***multi-bed*** monitoring. And Cardiac Resuscitation Systems for ***ultimate*** therapy.

Today, over 15000 Cardiart® ECGs, 1000 BPL Defibrillators and 2000 BPL Bedside Monitors are working satisfactorily all over the country. Proof that BPL are undisputed leaders in the field.

Prestigious technical tie-ups. Continuous product development. A comprehensive manufacturing infrastructure. And over two decades of invaluable experience. BPL's commitment to life-saving reliability continues....



BPL-INDIA

In pursuit of perfection

Computers ● Communication ● Components
Instrumentation, (Industrial, Medical & Measurement) ● Office Automation ● Consumer Electronics

CENTRAL MARKETING ORGANISATION BPL Towers, 13, Kasturba Road, Bangalore 560 001. Phones: 214990/214991

SALES OFFICES: ■ BANGALORE Phones: 561598/574787, Telex: 0845-2511, ■ BHOPAL Phone: 61046, ■ BOMBAY Phones: 4925398 4925361 4922918/4922933/4938704/4938392. Telex: 011-73789, ■ CALCUTTA Phones: 431658/448566, Telex: 021-2390. ■ COCHIN Phone 361506. ■ COIMBATORE Phone: 310502. ■ HYDERABAD Phone: 231091, Telex: 0424-6064, ■ MADRAS Phones: 471378 479420 474309 Telex 041-6507 ■ NEW DELHI Phones 6434309/6411035/6431886/6433865/6433689. Telex: 031-2692. ■ PALGHAT Phones: 3241 2. Telex 0852-213

Care before birth

Dr B M Lava

In every child who is born, under any circumstance and of no matter what parents, the potentiality of the human race is born again and in him too, once more, and of each of us, our terrific responsibility towards human life.

James Agee

The importance of prenatal care had been well-understood in the olden days in India. But prenatal care as we know it today is a relatively modern development. Pregnancy is a normal physiologic event. It is occassionally complicated. Good prenatal care avoids factors dangerous to the health of the mother and the foetus.

The principal aim of prenatal care is to ensure, as far as possible, an uncomplicated pregnancy. It tries to ensure the health of the mother and the safe delivery of a live, healthy infant. It tries to identify and manage the high-risk patient.

Pre-marital health check-up:

A girl should undergo medical check-up before getting married so that she is fit enough to meet the needs of the baby when she becomes pregnant. During the check-up, health education must be given. The harmful effects of smoking on the growing foetus should be emphasized. Nutritional deficiencies should be corrected. All girls should be immunized against rubella and tetanus. Premarital genetic conselling helps to reduce the incidence of genetic disorders.

What is the ideal age for child bearing:

Between 20 and 30 years. Discourage too early and too late marriages.

Care of the mother during pregnancy:

Early diagnosis and management of disorders, if any, are essential.

High risk factors (Before Conception):

a) Undernutrition of mother, height less than 145 cm, weight less than 40 kg, anaemia (with haemiglobin less than 8 g%); b) Age less than 20 years or more than 35 years; c) Pre-existing chronic illness, such as diabetes mellitus, high blood pressure or thyroid disease; d) History of past difficult deliveries, abortions, still-births, death of the newborn, low birth weight and developmental defects.

High risk factors (After Conception):

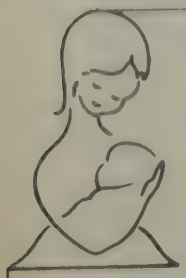
a) Pregnancy-induced high blood pressure; b) Maternal infections; c) Multiple pregnancy; d) Slow growth of the foetus; e) Rhesus iso-immunization; f) Premature labour; g) Antepartum bleeding; h) Cephalo-pelvic disproportion; i) Poly-and oligo-hydramnios; j) Abnormal presentations; k) Foetal distress; l) Prolonged rupture of membranes.

Foetal monitoring:

During the past 20 years, technological advances have taken place in monitoring the welfare of the unborn child. This cannot be said to be an unmixed blessing. Sometimes, it can lead to unnecessary interference.

Foetal maturity:

Evaluation of a foetal maturity is useful. There are many methods, including some which are imprecise, like foetal size. The size may not reflect the foetal age in conditions such as diabetes or intra-uterine growth retardation. Recent method is to evaluate organ system maturity, especially the foetal lung. Menstrual



history also gives an indication of gestational age and maturity but its shortcomings must be recognised. Measurement of uterine fundal height serially with a tape measure, is also a less accurate way to assess age of the foetus.

Foetal radiation is harmful. It is no longer appropriate to use X-rays for the purpose of estimating the age of the foetus.

Ultrasound could be used for more accurate determination of the gestational age.

Foetal lungs:

The most important factor for survival of the newborn is the maturity of the foetal lungs. Maturity of other organs may also be important.

Utero-placental unit:

It has been possible to assess placental function in the antepartum period with new biochemical monitoring methods. When poor function is detected, it is termed as utero-placental insufficiency.

Maternal conditions are usually related to chronic vascular disease, which by decreasing the intervillous space blood flow, limits respiratory and metabolic exchange across the placenta.

The placental function impairment can be associated with many clinical findings such as

a) failure of uterine growth in the third trimester; b) meconium in the amniotic fluid before or during labour; c) abnormal foetal heart tones during labour; d) asphyxia neonatorum; e) small, infarcted placenta; f) neonatal meconium aspiration; g) intra-uterine foetal growth retardation and h) intra-uterine foetal death.

The methods employed for assessment of uteroplacental function are estriol, non-stress monitoring and oxytocin challenge test (OCT).

Estriol:

The estriol production results from conversion of foetal adrenal androgen precursors to estriol by the placenta. The mean unconjugated plasma estriol increases from 6ng/ml at 28 weeks to 18 ng/ml at term.

Non-stress monitoring:

Has been suggested as an antepartum test of foetal well being. If the foetal heart rate accelerates by 15 beats or more in association with foetal movement twice in a 20 minute period, the foetus is said to be reactive.

Oxytocin challenge test:

Uniform foetal heart rate slowing following the peak of a uterine contraction during labour has been associated with foetal hypoxia and intra-uterine death. This foetal heart rate pattern is known as late decleration or Type II dip, and is considered to be ominous.

In this test, foetal heart rate responses are observed to oxytocin induced uterine contractions prior to labour, as a measure of uteroplacental function. Persistent, recurring late deceleration determines a positive test, when delivery should be hastened.

Intra-Uterine growth retardation (IUGR):

Intra-uterine growth retardation itself is no cause for delivery until uteroplacental insufficiency appears. Foetal indicators for delivery include a decreasing plasma estriol (by 40%) and abnormal non-stress and stress monitoring of the foetus.

Care during labour:

Normal labour is defined as that degree of labour that does not encroach significantly on the foetal margin of reserve. This is important as a foetus, already compromised as the result of any maternal medical complication of pregnancy, may not be able to tolerate the few minutes of labour.

Each uterine contraction is a repetitive mechanical stress to the foetus. It affects in a number of ways, such as, umbilical cord compression and impedance of intervillous space blood flow, which results in a transitory decrease in maternal foetal transfer of oxygen.

Foetal heart rate:

The variable deceleration, which varies from contraction to contraction, as does the onset of the deceleration in relation to the beginning of the uterine contraction, is an ominous sign, as it can result in foetal asphyxia and death.

In addition to the Foetal Heart Rate (FHR), careful observance of simple clinical procedures diminish the foetal hazards of labour.

a) Choose with care the drugs, if any are used, for analgesia and anesthesia, so as to minimize foetal depression; b) Keep the mother in a lateral position to

avoid supine hypotension; c) Monitor uterine hyperactivity with care, especially when inducing labour; d) Hydrate the patient sufficiently and e) Exercise gentleness during delivery so as to minimize trauma to the foetus.

Diagnosis of foetal distress:

Warning signals:

a) Diminishing baseline foetal heart rate variability; b) Mild variable deceleration and c) Tachycardia of 160 beats/min or greater.

Ominous signs:

a) Variable deceleration lasting more than one minute and dropping to 60 beats per minute or less and getting progressively worse.

b) Late deceleration of any magnitude, with or without tachycardia. If it is associated with a smooth baseline foetal heart rate the situation is more serious.

Rational treatment of foetal distress is based on an understanding of the underlying mechanisms. Corrective measures include:

a) Change the position of the patient: This may remove pressure from the umbilical cord by changing the physical relations between it, the foetus and the pelvis. If late deceleration is present because of supine hypotension, turning the mother to either lateral position will correct it.

b) If hypotension is present, elevate the patient's legs; she should be well hydrated.

c) Decrease uterine activity. If oxytocin is being used for induction of labour, discontinue the infusion.

d) Administer oxygen at the rate of six to seven litres per minute with a tight face mask. This measure may permit a slight increase in the oxygen delivered to the foetus and in some instances will alleviate or modify mild late deceleration and

e) Prepare for operative delivery.

CARE AFTER BIRTH

Immediate care after delivery:

After separation from the mother, the baby must breathe immediately or should be made to breathe, because within two minutes of tying the cord, the arterial oxygen tension falls to 1-2 torr units.

The quantitative assessment of the newborn described by Dr.Virginia Apgar remains the simplest and best way to evaluate the condition of an infant after birth.

APGAR SCORE

	0	1	2
Heart Rate	Absent	Less than 100/mt.	More than 100/mt
Respiratory effort	Absent	Weak Cry	Strong Cry
Muscle tone	Limp	Some flexion	Good flexion
Reflex irritability (when stimulated)	No response	Some motion	Cry
Colour	Blue or pale	Body pink extremities blue	Pink

Normal Score: 7-10 Moderate asphyia: 4-6 at 1 mt.
Severe Asphyia: less than 4

Temperature: As soon as the child is born clamp the cord, blot the infant dry with a sterile towel and place the infant under a radiant lamp, on a sterile table.

Airway: Gently suction the mouth and nose. If the infant's respiration is vigorous, nothing more may be necessary.

Breathing: If the infant is not breathing or the respiration is slow and irregular, place a mask over the infant's face and ventilate with 60% oxygen, using intermittent positive pressure from the anaesthetic bag. In mildly asphyxiated infants, this will produce a prompt increase in heart rate and the onset of regular, spontaneous respiration. If both do not occur, the trachea should be intubated and assisted ventilation continued. If the infant does not make strong respiratory efforts after the initial assisted ventilation and if mother has received morphine or pethidine within hours before delivery, a narcotic antagonist should be given (Naloxone hydrochloride 0.01 mg/IM)

Cardiac massage: If the heart rate remains below 50/min. after onset of assisted ventilation or if there is no audible heart beat, the heart must be massaged manually. Begin external cardiac massage by placing both hands around the infant's chest, with the fingertips towards the back, and the thumbs overlapping each other on the midsternum, then

quickly press down firmly with both thumbs at a rate of 80 to 100 strokes/mt. Co-ordinate the massage with the ventilation: Three heart beats, pause for one breath; three heart beats; pause for one breath, and so on. Increase the inspired oxygen to 100%. If there is no spontaneous heart beat, the infant needs intracardiac adrenaline (0.1 ml/kg. of 1:10,000 solution). However, most cases of presumed cardiac arrest are actually profound bradycardia which respond to effective ventilation alone or to cardiac massage.

Infants who do not respond rapidly to these measures will require prompt correction of acidosis. No bicarbonate should be infused unless ventilation is being assisted effectively.

Monitor body temperature: Infant kept under radiant lamp should have frequent temperature monitoring.

Prevent hypoglycaemia: After relieving hypoxia and acidosis, begin a steady infusion of 10% dextrose in water.

Meconium aspiration: Rarely present before 34 weeks of gestation, can occur from gasping efforts of the asphyxiated foetus, or with the first breaths after birth. Prompt suctioning of the airway at birth can often prevent or reduce the severity of the disease.

Routine care of the baby in the labour room:

After having ensured that the baby is breathing and adequately protected from cold, the following should be done.

a) Clean the eyes with sterile normal saline. (Silver nitrate prophylaxis is not recommended due to the danger of chemical conjunctivtis).

b) Tie the umbilical cord with two ties. Injection Vitamin K, 0.5–1 mg IM, to all babies with asphyxia and preterm babies.

Care of the normal baby:

Skin care: The baby must be cleaned off blood, mucus and meconium. The baby should be bathed or sponged next morning using unmedicated soap and lukewarm water.

Umbilical stumb: Triple dye should be applied at the tip and around the base of the umbilical stump to prevent colonization. Dressing should not be applied.

Eyes should be cleaned daily with sterile cotton swabs soaked in normal saline using one swab for each eye.

The following danger signs should be closely watched for and brought to the notice of the doctor.

a) Bleeding from any site; b) Appearance of jaundice within 24 hours of age; c) Failure to pass meconium within 24 hours and urine within 48 hours; d) Vomiting or diarrhoea; e) Poor feeding, undue lethargy or excessive crying; f) Excessive frothiness or drolling; g) Choking at feeds; h) Respiratory difficulty and / or cyanosis; i) Sudden rise or fall in the body temperature and j) Evidence of superficial infection.

Weight record:

Most babies lose weight during first 2-3 days, which varies between 5-8 %of birth weight. Birth weight is regained by the end of one week.

Breast feeding:

The first feed should be offered as soon as the baby is keen to suck and the mother is well enough to suckle.

The breast milk is free from contamination, is available at the desired temperature, and is easily digestible and suited to the needs of the infant. It has anti-infective properties. Breast feeding ensures a close physical and emotional contact of the child with mother.

Prevention of infections:

a) Separate nursing staff for care of newborns, if in the hospital; b) Frequent washing of hands; c) Individual care of infants; d) Isolation facilities; e) Dust control and use of disinfectants; f) Care of incubators and bassinets, including scrubbing with disinfectant solutions between cases; and g) Routine prophylactic use of antibiotics is not recommended.

Maternal nutrition and foetal outcome

Dr. R. Narayanan

Nutrition has profound implications on one's health and well being. The obstetrician by virtue of being the "woman's doctor" is often responsible for the primary health care of a substantial proportion of the female population. His responsibility multiplies manifold when he has to deal with the pregnant or lactating woman, in whom the nutritional demand escalates and he has to advise her accordingly.

During the course of pregnancy, the mother undergoes a remarkable series of physiological adjustments. This is to provide for foetal growth and development and at the same time, preserve maternal homeostasis. The resultant physiological system is complex, integrated and intricate.

The growing foetus in utero constantly makes increasing demands on the mother. Even when her intake is sufficient, the possible lack of nutritive value of the food, impaired absorption and defective utilization of resources can adversely affect the maternal physiology and foetal development. To obtain optimum benefits from nutrition, the maternal system has to strike a fine balance between intake of food, absorption and utilization. When this cannot be achieved, the developing foetus suffers and the obstetric outcome can be a near disaster.

Energy

The energy requirement in the non-pregnant state will largely depend upon the woman's basic metabolism and also on the extent of her physical activity. The more strenuous her exertion is, the more the energy requirement. During pregnancy on the other hand, the energy requirements are elevated because of the increased basal metabolic rate, the additional energy required for the growth of maternal tissues and for the growth of the foetoplacental unit. The total energy cost during the whole of pregnancy has been worked out to be in the region of 75,000 k cal.

The calorie expenditure remains at the same rate even after the onset of pregnancy until the late first trimester. The expenditure increases gradually to reach a plateau which is maintained until after full term delivery. In the second trimester, energy is required for the expansion of blood volume, growth of tissues in uterus and breasts and for the storage of adipose tissue. At term, the calories are spent for the foetal and placental growth. The Recommended Daily Allowance (RDA) of calories would be between 1900 and 3000 kcal/day during the non-pregnant state depending on the woman's physical activity and during the latter half of gestation, she will require an additional 300 kcal/day.

Proteins

Considering the protein requirements during pregnancy, the amnioacids derived from the dietary proteins are essential for the expansion of maternal plasma, the growth of uterus and breasts and for the foetal synthesis of proteins. The RDA would be 45-60 Gms/day which is approximately 15 Gms more than the non-pregnant requirement per day.

Gross deficiency of proteins in the diet will lead to intrauterine growth retardation (IUGR) and low birth weight (LBW) infants. Severe protein deficiency in the first trimester will result in decreased number of nerve cells in the brain. A similar deficiency in later pregnancy would result in a diminution of cellular size in the brain. Correction of such protein depletion will increase the size of nerve cells but not their number. In experimental animals, this damage has been shown to affect their maze-solving capability. Energy and proteins are usually grouped under one heading as it is difficult to separate their metabolic relationship. The energy as well as protein requirements are further elevated during the lactation period.

Weight gain

Even though there are some controversies regarding the exact significance of weight gain during pregnancy, the pattern and extent of weight gain have been consistently same in most studies, the total gain being approximately 10 to 12.5 kg. Of this, about half is maternal and the other half foetal. The maternal factors are the expanded blood volume, increase in the volume of uterus and breasts, deposition of adipose tissues and extracellular fluid volume. The foetal factors apart from the foetus itself would be the weight of placenta and liquor amnii. During the first trimester, the woman gains only about one to two kg. Later on, the weight gain is steady, varying between 0.35 to 0.5 kg per week until full term. Among the factors which influence the birth weight of the foetus, maternal weight gain is the second most important, the first being the duration of gestation. The maternal prepregnant weight is also an influencing factor.

The incidence of low birth weight infants (LBW) is more in the case of a woman who was underweight at the time of conception and also in a woman who fails to gain adequate weight. Overweight, obese women who conceive are likely to develop medical complications like hypertension and diabetes which by themselves will result in Intra Uterine Growth Retardation (IUGR) and low birth weight infants.

If there is excessive weight gain during pregnancy this may indicate oedema (hidden or seen) and sometimes increased adiposity. In either case, incidence of pre-eclampsia is increased which in turn can result in IUGR and LBW infants.

Dietetic counselling and supplementation of suitable nutrition are increased both in the underweight mother and the woman who fails to gain adequate weight during pregnancy. Severe dietetic restriction can be harmful in the overweight mother, not only because of the possible deficiency of other nutrients in the diet but also because of the ill effects of starvation. The catabolism of fat stores will lead to ketonemia and this has been shown to affect the fetal central nervous system. As a result, the intelligence Quotient (IQ) of such babies may become low.

Fluid retention as a cause of excessive weight gain must be differentiated from weight gain due to fat deposition. In the latter case, dietetic restriction may be beneficial and the aim would be to maintain the weight gain to near normal level.

Iron

The demand for iron goes up during pregnancy to meet with the increased maternal red cell formation and for the requirement of the foetoplacental unit. Some iron is saved by the absence of menstrual loss during pregnancy and the total requirement works out to about 600 to 800 mg.

The iron content of the average diet is only 10-15 mg/day of which only 10% is being absorbed. This is insufficient to meet the demand. Further, loss of small amounts of iron occur in sweat, urine and feaces. In a setting like ours we must also consider the possibility of pre-existing anaemia as a result of malnutrition, frequent pregnancies and androgen

---

Adolescence is the age at which children stop asking questions because they know all the answers.

Some adults are willing to blame juvenile delinquency on everything but heredity.

Shouting at children to make them obey is like using your horn to steer the car — and you get about the same results.

Television has changed the child from an irresistable force into an immovable object.

deficiency. Hence iron supplementation becomes essential during pregnancy, the RDA being 30-60 mg/day.

The foetus is seldom affected by the iron deficiency. Numerous studies have proved the foetal haemoglobin to be unaffected despite severe maternal iron deficiency. But the iron stores in these infants may be low and this may lead to increased incidence of neonatal anaemia.

Severe anaemia is the cause of IUGR in many instances. These Small For Date (SFD) babies suffer from an additional risk of morbidity and mortality.

Folic acid

Folacin is essential for the DNA synthesis of the rapidly dividing cells in the foetus. Folic acid requirements are further elevated in multiple pregnancy. The RDA is about 800 micrograms per day which is about double the nonpregnant requirement. Folate deficiency will result in megaloblastic anaemia. Folic acid deficiency may be linked to an assortment of conditions like antepartum haemorrhage (APH) abruptio placentae in particular, increased risk of spontaneous abortions pre-eclampsia and congenital malformations among which are included neural tube defects.

Calcium

A depressed level of calcium will stimulate the production of parathyroid hormone which maintains the serum level of ionic calcium. The ionic calcium is transported to the foetus across the placenta by concentration gradient. This relative hypercalcaemia in the foetus will depress the foetal parathyroid hormone which in turn will stimulate secretion of calcitonin. Calcitonin is required for foetal skeletal calcification and bone growth.

Thus the maternal calcium is utilized almost in toto by the foetus for its skeletal calcification. The RDA of calcium is 1000-12000 mg/day during pregnancy. The ordinary diet does not contain so much calcium and hence dairy products and milk in particular are essential during pregnancy. If this intake is deficient, supplementation becomes necessary.

Age attributed leg cramps in pregnancy is due to possible hypocalcaemia. He further hypothesised that the increased phosphate in milk may further aggravate this deficiency. Decreased calcium and vitamin D intake during the latter weeks of pregnancy can precipitate neonatal hypocalcaemia in the foetus. We should also keep in mind the risk of hypervitaminosis D and infantile hypercalcaemia.

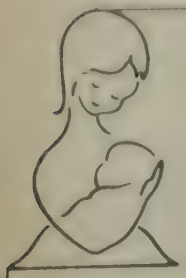
Vitamins

Among the vitamins, the requirement of fat soluble vitamins, namely, vitamin A and D, do not increase during pregnancy. By contrast, all other vitamins are required in larger doses during pregnancy. Pre-eclampsia has been associated with deficiency of both Vitamin C and Vitamin B6. There have been some reports associating ascorbic acid with the integrity of the amniotic membranes. They postulate that vitamin C deficiency may be the cause of premature rupture of membranes. Over-dosage of fat-soluble vitamins during early pregnancy may result in congenital malformations.

Electrolytes and Minerals

Of late, various studies have concentrated on the requirements and deficiencies of trace elements like zinc, magnesium and copper. More surveys in future will shed light on the importance of these.

The changes in sodium metabolism is significant during pregnancy. The increase in glomerular filtration rate by almost 50% during pregnancy would augment the sodium losing effect of progesterone and posture. This sodium loss will be compensated by the renin — angiotensin — aldosterone mechanism particularly through the increased tubular reabsorption of sodium, thus maintaining the sodium balance. Sodium does have a role to play in the development of oedema. Oedema of pregnancy could be due to mechanical factors like venous compression in later weeks of pregnancy or due to sodium and water retention occurring as a result of elevated oestrogen levels. The significance of sodium metabolism in pre-eclampsia is still controversial. The traditional theory attributed pre-eclampsia to insidious sodium retention basically and hence salt restriction was advised. But, the present thinking is to rely on tubular physiology. The advice to the pregnant woman is to take salt to taste but not in excess.



It becomes evident that the pregnant woman requires adequate calories and proteins to meet the increased energy expenditure and supplementation of various nutrients like iron, calcium, folic acid, vitamins and minerals. If these dietary allowances are translated in terms of actual food, a chart of balanced diet would ensue.

Our staple diet is rice, which supplies carbohydrates which is the source of 85-90% of calories and only 8-15% of proteins. If cereals are not refined, they will provide additional proteins and also B complex vitamins. If the entire protein requirement is to be met by intake of rice alone, one has to take 500 g of rice per day which amounts to five large bowls of rice as the only food!

Hence, it becomes essential to include other sources of protein like pulses, milk, nuts and legumes in case of vegetarian food. The vegetables are also essential as they are a good source of vitamins and folic acid. And most of the Vitamin C comes from fruits. The meat, poultry and fish in non-vegetarian food supply B complex, minerals, calcium, phosphorus and iron in addition to first class proteins.

The words 'Nutrition' and 'Diet' somehow tend to sound like medicines and drugs which are to be taken for one's health and well being. What we actually take is "food" which is a word that is pleasant and appetizing. To put it simply, all that the pregnant woman needs, is good wholesome food with some supplementation. This by itself would ensure insurance against many a mishap during her pregnancy.

Infant Mortality: A Social problem with health consequences

There is usually a correlation between the per capita gross national product (GNP) and the general health of a society but not always. The per capita income of Sri Lanka and Kerala state are low and yet the infant mortality rate is also low. Their success in lowering infant mortality prove that progress is possible despite great odds and even severe economic hardships. When the needs of children are high on a country's or a community's political and societal agenda, reduction of infant mortality rate is possible, even in low income countries.

Scandinavian countries and Japan have the lowest infant mortality rates. They have extensive systems of financial benefits for pregnant women and children.

The average European working woman is entitled to six months of paid maternity leave and often, an additional one year of unpaid leave. This helps the mother to stay home and breastfeed the baby and also to look after the child, if the child has any illness.

"The U.S. has no national or federal law giving working women the right to take leave from work for a specified period of time, guaranteeing the same or comparable job on their return, with at least some part of their earnings while on leave "said Sheila B. Kanerman, Columbia University School of Social Work. Only five out of the 50 U.S. states have laws to provide insurance giving pregnant women part of their wages for 6-8 weeks following child birth. Not all these states guarantee women their jobs back when they return to work. Result: U.S. with a very high GNP and all its wealth ranks only 17th in infant mortality rate.

Paul Teixeira, in Action for Children, No. 2, Vol. 3, 1988.

Under-five mortality rate

The under-five mortality rate is an index developed by the UN Population division, with UNICEF support. It is the number of children who die before the age of five for every 1000 born alive.

The number of deaths of under-fives is high in our country being over 40 lakhs in 1987, the highest in the world and quite staggering. The rate is 152 per 1000 live births. Compare this with rates of seven in Sweden and Finland, eight in Japan and Switzerland and nine in Canada and Netherlands. Many developing countries are much better off than India, e.g., Cuba: 19; Jamaica: 23; Kuwait: 23; United Arab Emirates: 33; Malaysia: 33; Sri Lanka: 45; China: 45; Thailand: 51.

Source: UNICEF annual report, 1989

Pregnancy and child birth

Pregnancy and child-birth can be a very exciting but trying time for you, especially if you are expecting your first child. Every time your child moves around in your womb, the wave of motherly love that engulfs you could be stupendous in its intensity. You may feel very awkward in your movements, ungainly and unattractive. But pregnancy need not be a trying time. If you understood the changes taking place in your body and took a little care about eating the right food, pregnancy and child birth could be a fun time.

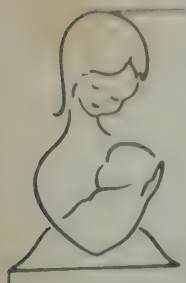
***Chanda Agashe** tells you all about it.*

Child bearing imposes great strain and it is important that the would be mother leads a healthy life, throughout pregnancy. One of the major factors that promote health and well being, both of the mother and baby in the womb is wholesome, nourishing food.

For the rapid, all round growth a foetus needs readymade nutrients which are solely derived from the mother's body through her blood stream. Is is therefore necessary that throughout pregnancy, the mother pays special attention to the kind and quantity of food. Upto the 12th week, the embryo relies wholly on the surrounding tissues for its nourishment but after the 12th week nourishment is solely derived from the mother's blood stream.

Certain important changes take place in the mother. They are: 1) Increase in overall size of her body. 2) Enlargement of the child bearing organs to accomodate the developing foetus. 3) Increase in breast tissue to meet subsequent demands for lactation. 4) Increase in the amount of circulating blood to facilitate the supply of nourishment to the newly built tissues.

During the early weeks of pregnancy, nausea and vomiting is commonly found. It not only results in limited food intake but may result in loss of nutrients. Hence a pregnant woman should have good quality food to offset the effects.



Surveys indicate a high incidence of malnutrition among pregnant women of the poor socio-economic group. Maternal malnutrition has the following consequences:

The birth-weight of the baby is low. The low birth-weight is a sign of immaturity and indicates that the baby s organs and tissues are not developed fully. High incidence of immaturity in turn leads to high infant death rate during the first few days of life.

The infants who manage to survive the first few weeks either develop nutritional diseases like anaemia, rickets, etc or suffer from recurrent infectious disease because they lack the power of resistance.

Effect on Maternal Health is if diet during pregnancy is inadequate, she supplies nutrients to the foetus by withdrawing them from the tissues of her own body. The "tissue depletion" weakens her so much that she is unable to cope with the strain of child bearing.

EFFECT OF AGE:

Adolescent Pregnancies:

Studies have shown that perinatal, neonatal and infant mortality rates were significantly higher in infants born to girls under 16 years of age. Also there are more cases of toxemia and an increased number of premature delivery and low birth weight infants. As reported in Indian studies about 30% of first pregnancies occur in teenagers especially in poor communities where resources are seriously constrained. Pregnancy in an already deprived girl, who has to meet the requirements for growth and pregnancy could result in poor obstetric outcome. The adolescent girls from the poor class not only have low body weights and a low body mass but are also at a disadvantage due to contracted pelvis, resulting in higher surgical intervention.

Nutritional requirement for the adolescent during pregnancy vary widely, depending on the growth and maturation of the expectant mother. As calorie requirements parallel the growth curve, these girls have high calorie needs. Protein and calcium requirements are also high. Calorie restrictions imposed on these girls may not only affect the birth weight of their infants, but their own adult stature.

Older pregnancies:

Pregnancy after 35 years of age is influenced by the individual's overall health. There are several maternal risks involving pre-existing medical conditions, such as diabetes, kidney disease, hypertension, cardiovascular problem and leiomyoma uteri. As the mother's age increases, her baby is more likely to be premature and smaller than average.

Studies abroad have shown that as age increases there is a significant rise in essential hypertension. This is the effect of aging on the vascular system. Additionally the presence of chronic hypertension increases the risk of super imposed pregnancy induced hypertension, possibly to a five fold magnitude.

A higher incidence of overweight at the time of conception might be predicted among older women. Because weight control reduces both blood pressure and obstetrical risk, it is advisable to have a calorie-restricted diet before conception to reduce the risk.

The caloric needs may be at least four percent less than for younger pregnant women, owing to lowered resting BMR and less activity. Hence it is important to have high nutrient density foods to meet the requirement of other nutrients. This can be achieved by judicious planning of foods that are high in other nutrients, but low in calories.

Effect of Height and Weight:

Studies in India have indicated that maternal height does not have any significant influence on low birth weight.

However pre-pregnant maternal weight below 40 kgs has greater impact on low birth weight of the infant. Low maternal weight is an indication of maternal nutritional status, and one can assume that poor energy intake in pre-pregnant status has a greater impact on foetal weight.

Effect of Socio economic Status:

Studies on dietary intake of pregnant women from the low socio-economic group in India have shown following facts —

a) Dietary intake is lowest during the first trimester. This might be due to nausea and vomiting during early stages.

b) Dietary intake of pregnant women is same as during non pregnancy. This may be due to economic constraints and partly due to lack of awareness that pregnancy calls for an increase in dietary intake.

Balanced Diet:

"A balanced diet" is one which contains different types of foods in such quantities and proportions that the need for calories, minerals, vitimins and other nutrients is adequately met and a small provision is made for extra nutrients to withstand short durations of leanness.

Balanced diet during pregnancy contains adequate amounts of all the essential nutrients needed to maintain the health of the pregnant woman, and child in her womb.

Balanced Diet for a Pregnant Woman

Food Group		Food stuff	Amount/ gm
I (energy yielding)	a)	rice, wheat, and millets	350
	b)	oil ghee, butter, etc	35
	c)	Sugar and jaggery	40
II	a)	Milk, curds etc	225
	b)	Pulses, dried beans, nuts	45
	c)	Meat, Fish, Egg	60
III	a)	Fruits	30
	b)	Green Leafy Vegetables	150
	c)	Other Vegetables	125

Medical News

Physical Fitness Habits

Why do some people continue to be active as adults and others don't? A retrospective study of young men showed that those who did well on physical fitness tests as children were more physically active as adults than those who had scored poorly on the childhood tests. Physical fitness, if learned young, becomes a lifelong beneficial habit. **Pediatrics.**

The balanced diet given in the table is for those who consume flesh foods and eggs.

However because of financial constraints it may not be feasible to eat flesh foods. Then following changes can be made —

a) Increase milk and milk products and pulses.

Changes in Balanced Diet:

Changes may be made for these women belonging to low socio-economic group.

Cereals: a)rice used along with other millets (b) use of paraboiled rice.

Pulses: Variety of grams and beans can be used by sprouting. Sprouting improves nutritive value and flavour. It makes pulses more digestable. Pulses can be used along with milk.

Egg, Meat, Fish: Cheap meat like beef and small low priced fish can be used. Egg and milk can be used alternately.

Milk and Milk Products: A minimum of 110 ml. milk is necessary during pregnancy. Powdered whole milk can be used instead of fresh milk, if finances permits.

Green Leafy vegetables: They should be eaten at least three to four times a week. On other days proportion on milk, pulses and other vegetables should be increased. When leafy vegetable is not eaten, raw vegetable salad can be consumed.

Fruits: Seasonal fruits like oranges, lemons, grapes, mangoes, tomatoes, amla can be consumed as finance permits. If fruits are not available sprouted pulses can be used.

Other vegetables: They can be consumed, preferably raw, as available.

Fats and Oils: Since fat of any type is expensive the amount used is minimum required for good health. The minimum amount used is from seven to 20 gms.

Sugar and Jaggery: Jaggery can be used instead of cane sugar. It is also rich in Iron.

Remedies for baby rashes

Rashes are uncomfortable for babies, unsightly and sometimes worrisome for parents. But given young infants' tender skin, they're almost unavoidable. Here's a rundown of the most common rashes.

Diaper rashes. The diaper area is moist, warm, and poorly ventilated-conditions ideal for the development of the everyday kind of rash. Due mainly to bacterial action on certain chemical components of urine, which produces ammonia, a potent irritant, the rash is typically pinkish and pimply.

More frequent changing will help, as will fresh air, a couple of daily soap-and-water soaks (with thorough rinsing), and use of petroleum jelly or a similarly mild soother.

An eruption in the diaper area that doesn't respond to the simple measures suggested may signal one of three other problems, all of which need your pediatrician's attention:

Ordinary bacteria, which are ubiquitous on human skin, can set off infections in the diaper area; the rash is usually blistery. Antibiotic treatment is required.

This is also a frequent site of fungal attack by Candida, also known as Monilia or "yeast infection." The area is usually quite inflamed, with tiny pimples surrounding the reddened area. Special prescription ointment is needed. Check, too, for the possibility of thrush, an oral infection caused by the same organism, which takes the form of cottage cheese-like patches on the gums, tongue, and roof of the mouth.

In a condition called seborrhea the skin appears very red and raw, especially in the creases at the top of the thighs. Again, prescription medication is needed.

Atopic dermatitis: This is a patchy dryness due to hypersensitivity. It may occur anywhere but is frequently seen on cheeks and behind ears. The baby will be itchy and irritable (though unable to scratch under the age of about four months) and is likely to sleep poorly.

Atopic dermatitis in infants may be triggered by any number of factors, including detergents, contact with wool or other materials, or elements in the diet; it's often difficult to pinpoint the culprit. There's often a family history of allergy.

If this condition is suspected, it's a good idea to remove known offenders(feathers, wool, animals, scented lotions) from the baby's vicinity. Diapers and clothing should be thoroughly washed and rinsed, then run through a full wash with no soap, fabric softener, or other additives. And if you're breast-feeding, you should avoid common food allergens.

Your physician, meanwhile, can prescribe topical medication to relieve discomfort. And keep your baby's fingernails cut short; scratching could cause infection.

Impetigo. This infection, which is contagious, is caused by bacteria that normally live on the skin and take advantage of minor irritations to multiply and stir up trouble.

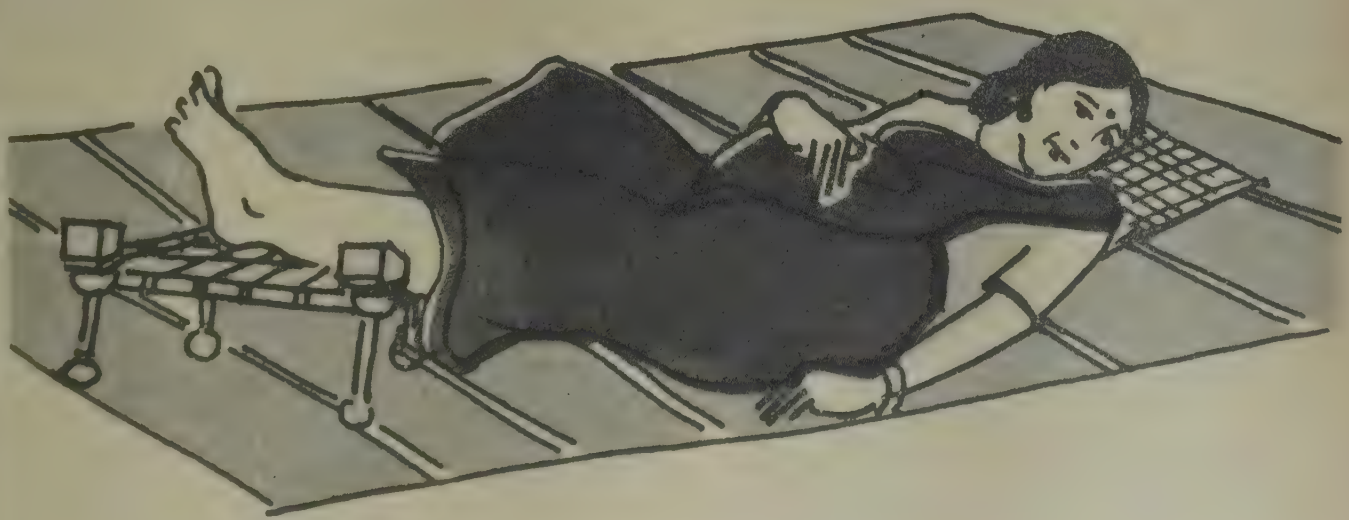
High-Risk Pregnancy

Dr Paula Adams Hillard M.D.

What is a high-risk pregnancy? Most women assume that pregnancy is a natural, normal process, and, most of the time, it is. However, obstetricians use the term "high-risk" to indicate a pregnancy in which there is a greater than usual chance of death or disability for either the mother or the baby as a result of a condition or conditions that complicate the normal pregnancy process. The knowledge that some diseases that the mother may have had prior to pregnancy, or may develop during pregnancy or labour, are associated with increased risks prompts obstetricians to try to identify these factors and to minimize the risks through appropriate care.

Pre-pregnancy considerations

Many chronic diseases such as high blood pressure or diabetes entail specific increased risks during pregnancy, and a discussion of these risks should take place prior to pregnancy if possible. Women with these and other medical illnesses should discuss the potential risks of pregnancy and their magnitude with their primary medical doctor and also with an obstetrician before they get pregnant. In some situations, the magnitude of the potential risks or the severity of the risk may be so high that an individual woman might decide not to attempt pregnancy. However, in many or most situations, special care and medical attention can minimize the risks. For example, a woman with diabetes would need to have her blood sugar tightly controlled both before and



during pregnancy in order to minimize the risks of birth defects or other pregnancy-related problems.

Women who have had problems with previous pregnancies should also consult with their doctors prior to getting pregnant again. Some pregnancy-related problems will recur with a subsequent pregnancy. A history of problems such as premature labour, stillbirth, neonatal death, repeated miscarriages, Rh sensitization, gestational diabetes, pregnancy-induced high blood pressure, placental abnormalities like placenta previa or a placental abruption, or a baby with birth defects, means that each subsequent pregnancy has the potential for increased risks. The likelihood that the condition will recur varies; some conditions, such as certain birth defects, are more likely to recur and lead to catastrophic problems such as fetal death. Other conditions, such as preeclampsia with a first pregnancy, may recur but are much less likely to be repetitive or severe.

Of course, only the individual woman or couple can make a decision about the magnitude of risk that they are willing to accept. For some conditions, the statistical likelihood of recurrence is fairly well established. For example, several medical studies have estimated that around 30 percent of women who have preeclampsia during their first pregnancy will have preeclampsia with a subsequent pregnancy. But that percentage may be interpreted in different ways. Some women would conclude that a 30 percent chance is quite high and that they would not want to risk another pregnancy. Other women would decide that their chances were 70 percent of not having a recurrence and would accept those odds and try again. Unfortunately for other conditions, especially uncommon problems, estimates of the risks of recurrence may not be available or reliable.

An important early step

The first prenatal exam is an extremely important one. Information about the past medical history and past pregnancies as well as information about habits such as smoking and alcohol use, and work requirements such as prolonged standing, walking, or heavy lifting, will help determine the magnitude of risk to the current pregnancy. These factors and others, such as the mother's age, her weight, high levels of stress or fatigue, or lack of support from partner or family may contribute to the risks of pregnancy complications, but are usually not alone sufficient to prompt a designation as a "high-risk" pregnancy. However, the combination of a number of risk factors may lead to an increased likelihood of risk.

One condition, preterm or premature labour, has received a great deal of focus on attempts to predict risk. This is because at least 60 percent of all infant deaths occur in babies weighing less than 2500 grams, or five and a half pounds, at birth. Long-term disabilities and handicaps are much more likely to occur in this group of low-birth-weight infants, so it is clear that concerted efforts to predict and prevent premature labour can have a significant impact on the risks of death and disability.

An initial designation as "low risk" does not mean no risk, and the obstetrical care-giver, whether it be a nurse-midwife, obstetrician, or family practitioner, must be continually vigilant to detect risk factors that develop during pregnancy or labour.

At whatever point in the pregnancy risk factors are detected, the significance of the specific risk should be explained. The care-giver should outline a plan of management. If the problem is unusual or severe, this might involve consultation or referral to a physician specifically trained to deal with high-risk obsterical problems. If the problem is less severe, the management might include recommendations for restricted activities, specific testing (ultrasound, amniocentesis, fetal-activity testing), diet, medication, blood testing, or more frequent prenatal visits. Obviously, the specific recommendations depend on the nature of the problem.

Work with your doctor. The individual woman whose pregnancy is termed "high-risk" will need to work with her doctor to do everything possible to lower the potential risks for herself and her baby. Communication is important, and she must be sure to ask enough questions to be able to understand the nature of the problem and the reasons for any recommended treatment or evaluation. The partnership between a woman and her doctor will result in lowering the risks as much as possible and increasing the likelihood that both mother and baby will do well.

Pregnancy and Obesity

Why weight causes problems

Women who are obese do face higher risks during pregnancy than do women who are of normal weight, although careful attention and good medical care during pregnancy, labour, and delivery can minimize those risks. A number of studies have reported that certain medical problems are more likely to occur during pregnancy for obese women, defined, depending on the study, as women with a weight above 90 kgs to 112 kgs at delivery.

Researchers report that women who are significantly overweight have an increased risk of developing pregnancy related, or gestational diabetes, which may require a special diet or insulin treatment to minimize risks to the mother and baby. High blood pressure also occurs more frequently in overweight women; more than 25 percent of pregnant women weighing over 90 kgs have elevated blood pressures (hypertension). Women with hypertension during pregnancy need to have careful obstetrical care to assure that the baby is growing normally. The most common problem that women with chronic hypertension face is that of a superimposed preeclampsia with edema, a sharp rise in blood pressure and protein in the urine. If untreated, seizures (eclampsia) may result, with significant risk for mother and baby unless delivery occurs soon. Labour may need to be induced or an early Cesarean delivery may be necessary to prevent further complications.

Other problems reported to occur more frequently in overweight pregnant women include the risk of having a very large baby. Large babies are at risk for a complication of vaginal delivery known as shoulder dystocia, in which the head is delivered but the larger shoulders get stuck, resulting in a very difficult delivery with possible trauma to the baby. Shoulder dystocia occurs more commonly in obese women. Babies who are post term (over 42 weeks)need careful monitoring to minimize the risk that they will outgrow their placental nutritive support and be at risk for distress during labour.

Several studies have found that overweight women are more likely to have problems with the progress of a labour. They are more likely to need oxytocin to augment their labour contractions,and the second stage of labour (pushing) is likely to be longer. Of course, very large babies will not "slip through" the vaginal canal and mother's pelvis as easily as will smaller-than-average babies.

What about the likelihood of obesity in babies born to heavy women? One study found that while there was no difference in the weights of babies born to heavy — and average weight mothers at six months of age, at one year, the babies of heavy women were more likely to be obese. This familial trend toward obesity may be due to genetic factors or overfeeding.

— Parents

Equipment for foetal monitoring

Dr. Gomathy Narayanan

The aim of good Obstetrics is to ensure a healthy mother and a healthy baby. Most of the time, we can rely on clinical skills alone. But in certain clinical situations, the obstetrician may have to seek the help of other investigations, if available.

Ultrasonography

One such useful tool is ultrasonography. As far is known, there is no known ill effect of ultrasound waves on the foetus or the mother. On the contrary, it gives us valuable information. This non-invasive investigation is a boon to the pregnant woman.

In early pregnancy, the obstetrician uses ultrasonography, whenever there is discrepancy in uterine height, suspicion of abnormal pregnancy, vaginal bleeding or pain in abdomen. Identifying foetal death, abnormal pregnancies like molar pregnancy, ectopic pregnancy and multiple pregnancy, uterine anomaly and tumours complicating pregnancy, becomes easier with the aid of this equipment. In advanced pregnancy, it helps one to check the foetal growth pattern and obtain information regarding placenta and liquor amnii. With its aid, we are also able to reasonably rule out foetal malformations. Under sonographic guidance, we can draw blood, amniotic fluid and obtain biopsy material from the foetus for investigations. Injection of medicines and administration of blood transfusion to the foetus in utero under its guidance are also possible. Even surgery on foetus can be performed in utero as a life saving measure.

Foetal heart rate monitoring

We have rapidly entered the electronic era. Bioelectronic foetal heart rate monitoring represents a new method of studying foetal physiology and recognizing foetal distress. This non-invasive technique is now being used increasingly as one of the tests to assess the foetal status. The non stress and contraction stress tests performed with the help of such a monitor yield results which are measurable and reproducible with specific end points.. It involves a safe, simple, and rapid testing methodology. The results obtained correlate well with foetal well being and is an indicator of the intact autonomic control over the heart rate of the foetus. Lack of oxygen in the foetus, which in turn is an indicator of unsatisfactory respiratory function of foetoplacental unit, can be reliably diagnosed. In short, bioelectronic foetal monitoring yields valuable information about the intra-uterine environment.

These tests are ideal for patients who are at a high risk for placental insufficiency and foetal wastage. The typical indications would be hypertensive disorders of pregnancy, diabetes in pregnancy, post dated pregnancy or when any clinical or laboratory findings indicate foetal compromise as it happens in intra-uterine growth retardation. These tests may have to be repeated where and when necessary to choose the optimum time for delivery for better perinatal outcome.

Jokes

A boy was not well and his mother asked him to buy a thermometer from the pharmacy. As he could not pronounce the long word and had got quite confused by the time he reached the chemist, he stuttered "Theri Ma meter." The chemist, angry at the cheekiness of the boy retorted, "Thera Bap centimetre".

Gareth Fern, ten years

A child was asked to study phrases for his home-work. But unfortunately it was Chitrahar day and the boy instead of doing his homework, watched Chitrahar. The next day when the teacher asked him if he had learnt his phrases, he promptly replied, "Hawa, hawa, eh hawa; ek do teen;... eh ji oh ji me hu manmoji;.... oye oye oye oye".

Kashyap Murali, seven years
Satyam Public School

Obstetric fistulae — its magnitude and implication

Dr K R Antony, MBBS, DCH, DTCH

Some women complain of continous dribbling of urine from their vagina. Their under clothes are continously wet and a constant stink of urine emanates from them as they walk around. Atleast some of them are embarrassed at the lack of control of flatus and faeces. They feel quite shy to tell anybody about their problem and avoid socialisation. They tend to become introverts. They are caught in a whirlpool of depression.

Well, all these troubles started after the last delivery. The labour was prolonged and there was no supervision by any medical experts. After some time, she noticed the leaking of urine.

This could be the story of many women in Bihar, U.P., Madhya Pradesh, Rajasthan and in the hilly north-eastern states. They struggle in their huts during the process of delivering their much awaited first offspring. A village Dhai reassures them without fully understanding the dangerous consequences. The net result of this tense drama is an anatomical artificial defect of the vagina called Obstetric Fistulae.

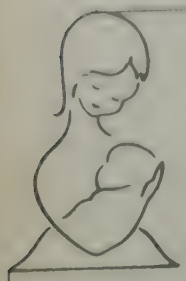
Obstetric Fistulae is a defect of the wall of the vagina resulting in a communication with the urinary bladder or urethra or rectum. This leads to incontinence of urine or faeces.

Why is it caused?

Obstructed labour: When the labour is prolonged the continuous pressure of the foetus against the wall of the mother's pelvis (the bony cage of lower abdomen and hips) give rise to death of the soft tissue it is pressed against. This happens when the baby's head is too big to come through the mother's pelvis (cephalo-pelvic disproportion). The localised death of the soft tissue, called necrosis, results in a hole in that area. If this hole is between the vagina and the bladder, urine as it is being formed will flow continuously from the bladder to the vagina. If this hole is between the vagina and the rectum similarly faeces can get squeezed out through the vagina.

Why do some mothers have a prolonged labour?

The commonest cause is either too big a head of the baby or too small a pelvis of the mother. A contracted pelvis usually results from a stunted growth of the woman by malnutrition and untreated infections in childhood and adolescence. Vitamin D deficiency leads to formation of a contracted pelvis.



Another reason for a small pelvis may be an early motherhood, the first pregnancy occuring soon after menarche, before the growth of the pelvis is complete. Remember child marriages are still prevalent in many parts of our country especially in Rajasthan

Induced Abortion: Induction of abortion through crude methods especially by unqualified hands in the rural area can also lead to a Fistulae. This is more common in rural areas.

Accidental Injury: Unintentional injury to the bladder can occur during caesarean section, difficult forceps delivery, craniotomy (destruction of the head of the baby in obstructed labour to save the life of the mother).

Socio cultural factors: Socio economic under development is the basic underlying factor responsible for maternal illhealth including obstetric fistulae. Behind the medical causes such as obstructed labour or injury to the urinary tract and other logistic causes such as poor facilities in the Primary Health Centre or Taluq hospital and poor transportation facilities, are the social, cultural and political situation of women. This determines the status of women, their nutrition, their health, their fertility and attitude.

If girls are less privileged to receive formal education and adequate nutrition the after effect on health of the future mother is going to be very negative in many ways. Without high school or university education when they remain at home it is natural for Indian parents to get them married early. A young girl without any fertility awareness and knowledge of birth spacing starts child bearing at too early an age. She has not understood the importance of antenatal check-ups and has not established any rapport with the basic health worker or ANM. At the onset of labour, the husband or mother-in-law will engage a Dhai to attend on her. What happens inside the dark room is only known to the Dhai or an elderly woman attending on her. Responsible decision makers of the family are totally kept in the dark as to the gravity of the situation.

Even when the patience of the relatives is thus tested, they continue to rely on the expertise of the Dhai, as transportation to a far off place at that critical juncture is very difficult and expensive. The end result may be an obstetric fistulae, if at all that obstructed baby managed to come out alive.

Magnitude and prevalence of Obstetric Fistulae in our Country

Data on the prevalence of Obstetric Fistulae will roughly reflect the type of maternal health care existing in a region.

Catholic Hospital Association of India had conducted a mailed questionnaire survey regarding Obstetric Fistulae among 42 major member hospitals in the country during the months of July and August 1989. In all 19 Institutions (45.2%) responded to the survey providing required information.

Though the survey was aimed at hospitals with more than 100 bed strengths, three hospitals were included with less than 100 beds for want of bigger hospitals in such states. Bed strengths varied from 70 to 750. The summed up current bed strength among these 19 institutions is 5527.

Total number of deliveries in all these institutions together constitute 42,041. Seven institutions had more than 2400 deliveries a year ie 200 per month.

All these institutions had post-graduate doctors to manage obstetric cases with experience in the field ranging from six years to 40 years.

Only 23 cases were seen and managed in all these institutions during the last year, where there were 42,041 cases of deliveries. So the incidence was 5.47 cases per 10,000 deliveries.

The incidence of urinary fistulae was one in 446 gynaecological admissions in Erskine Hospital, Madurai, India from 1961 to 1970. Ref: Bhasker Rao, K. Vesico-vaginal fistula — a study of 269 cases. Journal of Obstetrics and Gynaecology of India 1972: 22(5): 536-541. 97% of these fistulae at Madurai were of obstetric origin mostly due to prolonged, obstructed labour. Nearly 80% were in the age group of 15-30 years and 60% were after their first delivery.

In our survey 77.3% belonged to poor families. The maximum were in the 26-30 years age group and most of them developed after their first delivery.

The reported cases were mostly from Bihar, North Eastern states and Punjab in our study. "Twenty or more years ago, gynaecologists all over India were very familiar with obstetric fistulae but the development of peripheral maternity services and improved communications greatly reduced the incidence except in deprived areas such as Bihar, says a report of the technical working group on Obstetric Fistulae by WHO.

Management: Surgical correction of the fistulae is the solution to alleviate the suffering of these women. But in reality this is not easy to achieve. In our own reported 23 cases only 13 (56.5%) were surgically repaired. Major causes for non-correction were patients not turning up. May be because of their poor financial status and inability to pay hospital bills. A lack of awareness also led to poor mobilisation of finances.

Some cases could not be taken up for surgery because of the site and size of the fistulae and medical unfitness of the patient. Many mothers do not even approach a doctor out of sheer embarrassment in exposing their problem.

The repair of obstetric fistulae requires special techniques and great experience especially if the fistulae is a complicated one. There is a need to give training programmes to young surgeons by experts in pelvic surgery. It is better that cases of massive defects, fistulae with severe scarring, previous failed repairs etc., be referred to a special fistulae surgeon. Such surgeons can organise a fistulae surgery training centre for the benefit of other surgeons in district hospitals.

Prevention of Obstetric Fistulae:

Long-term strategies: Improvement in the socio-economic status of women, compulsory schooling of the girl child, more decision making capacity for women etc will pay good dividend towards better maternal health. Improvement of family welfare programmes, fertility awareness, skilled attendence during child birth and a better, efficient transporting facility for referral of complicated obstetric cases etc., are measures that should be undertaken in MCH services.

Community Level: Any mother less than 16 years of age with a height less than 150 cm in her first pregnancy or in subsequent pregnancies and if she had a previous history of a difficult labour should be identified. She should be referred to the nearest health centre for delivery. This message has to reach the Dhais in a convincing and non-threatening way. How will a Dhai know what is the end point or event during a difficult labour at which she should take a decision to refer a case? This has to be clearly defined.

Any difficult case from the periphery if transported for expert care to a district hospital should be eligible for immediate financial reimbursement. This is to cover the cost of transportation by a poor family in the absence of a free state ambulance service. Free surgical correction should be arranged by the state for poor patients.

Social rehabilitation of fistulae patients is another need so that they can return to their communities with self esteem restored.

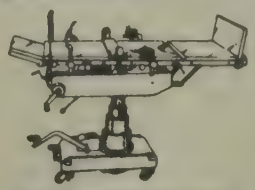
MCH services of taluq and district hospitals should be well geared to handle high risk cases screened from primary health centres. Supervision of labour of such cases should be very meticulous.

Obstetric Fistulae may be a personal problem of a very young short lady coming from a rural area where health services are poor. But it is as much a matter of shame and disgrace for us who claim to have a socialist democratic society. All efforts must be made to get rid of this stigma.

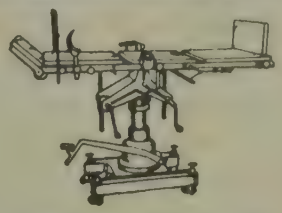
Hoslab

The house of best quality surgical operation theatre equipment

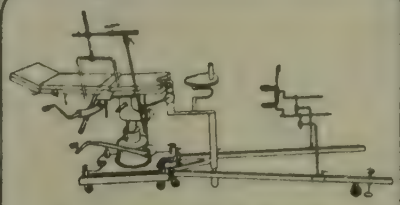
Surgical Operation Tables:



Major Head End Control Hydraulic Pump Multi-purpose Operation table

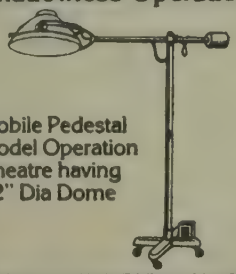


Delux Model Side Control Hydraulic Pump Multi-purpose Operation table

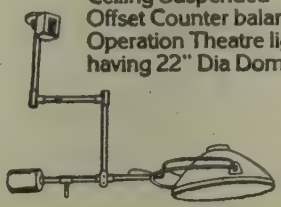


Ortho-Delux Orthopaedic and Fracture-Cum-Surgical Operation table

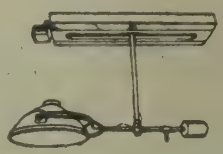
Shadowless Operation Theatre Lights:



Mobile Pedestal Model Operation Theatre having 22" Dia Dome

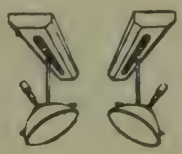


Ceiling Suspended Offset Counter balanced Operation Theatre light having 22" Dia Dome Dia

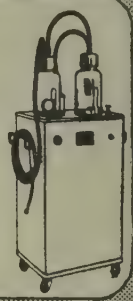


Track Mounted Ceiling Model Operation theatre light having 22" Dia Dome

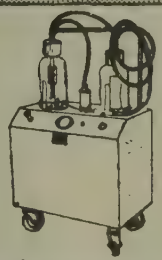
Track Mounted Dual (Twin) Ceiling Model Operation Theatre Lights having 22" Dia Domes



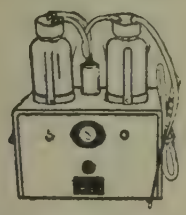
Surgical Suction Apparatus:



Major High Vacuum Noiseless Surgical Apparatus

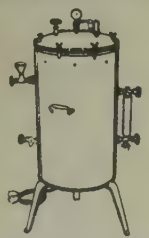


Delux Model High Vacuum Surgical Suction Apparatus



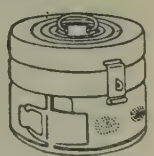
Portable High Vacuum Surgical Suction Apparatus

Sterilising Equipments:



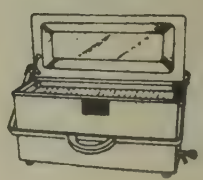
Vertical High Pressure Steriliser of Two Drum Capacity

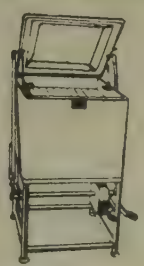
Single Drum Autoclave of One Drum Capacity



Dressing Drums.

Portable Instrument and Syringe Steriliser





Bowl and Utensil Steriliser

Stand Model Ward Instrument Steriliser

Hoslab Equipment Company

Factory, Regd. Office & Show Room at:
26-27, New Empire Ind. Estate,
Sree Ramakrishna Mandir Road,
J.B. Nagar, P.O., Andheri(E), Bombay-400 059.
Tel: 634 0772, 632 9250, 699826
Grams: Hospek-Andheri, Bombay-59

How to prevent LBW

Dr H V Vivekananda Murthy

A high proportion of the population in developing countries has limited access to medical services and only a small section of the society is being benefitted by the high quality of medical services. The universal coverage is limited due to the lack of resources, both manpower and financial. India has launched various schemes since the first Five Year Plan to improve the coverage and content of health care delivery system. However, the indices of health like infant mortality rate or neonatal mortality rate or proportion of Low Birth Weight (LBW) infants in India continue to be high. Hence, there is an imperative need to find ways of making optimal use of existing resources for the benefit of the population.

In any society, mother and children form the most vulnerable segments of the population; mothers because of their pregnancy and lactation, and infants on account of their age and requirements for their development.

An indirect assessment of the health situation at the national level shows that over the last three decades some of the indices of MCH care like LBW, prematurity rates, and perinatal and neonatal mortality rates have not shown the decrease commensurate with expansion of health service. This might be because coverage of the entire vulnerable population (pregnant and lactating women, infants and children) is with available limited health manpower and resources. Hence, this has resulted in a slow decline in neonatal and post-neonatal mortality. Innovation in the present health care system is needed to reduce the incidence of low birth weight. The flow diagram 1 shows the need for innovation such as risk approach in the existing health care delivery system. The risk approach aims at identification of the individuals at risk as early as possible, so that appropriate intervention is given to this identified high risk group, which might pay higher dividend in terms of reduction in morbidity and mortality.

The philosophy of Risk Approach

The high percentage of morbidity and mortality occurs in a small segment of population known as the high risk group.

It is feasible to identify the high risk group on the basis of socio-demographic characteristics, obstetric profile, health and nutritional status and other factors.

There would be a significant reduction in morbidity and mortality in the entire community, provided appropriate intervention is given to the identified small high risk group of population, which is the basic objective of the risk approach.

Model to identify women at risk

The aim of risk approach is to give special attention to those who are in the greatest need. The women from non-pregnant and non-lactating status can be categorised into high or low risk groups based on risk factors such as age, parity, inter pregnancy interval, previous reproductive loss. Women are categorised as being the high risk group when complications are detected during the current pregnancy. The appropriate antenatal visits to screen women for risk factors are 20 weeks, 282 weeks, 342 weeks and 382 weeks of gestation. At each visit the women are examined and classified into high or low risk group. The number of antenatal visits cannot be fixed as it depends on the risk involoved, the risk may be to the mother or child or both.

Importance of study of Low Birth Weight

The proportion of Low Birth Weight (LBW) reflects the socio-economic development of any region/country. Recognising the importance of birth weight measurement, the 34th World Health Assembly in 1981 recommended it to be one of the twelve global indicators for monitoring the health of

the community. The importance of studying birth weight is significant for reasons, viz.,

a) Birth weight is determined by the maternal health and nutritional status which are important causes of foetal growth retardation.

b) LBW exists universally in all populations and is the single most important determinant of the new born's survival and for healthy growth and development.

c) LBW leads to lower productivity compared to normal during labour force participation due to retarded growth and development.

Magnitude of Low Birth Weight

It was estimated that 127 million infants were born in the world during 1982, of which 20 million or 16% of infants weighed less than 2,500 gms at birth. However, their percentage in 1982 was less by 0.8 as compared to the incidence in 1979 (16.8%). For developing countries, the percentage had fallen from 18.4 to 17.6. The incidence of LBW varied among different regions of the world. In 1982, it was 6.9 percent in developed countries as against 17.6 percent in developing countries. The incidence was 19.7 percent in Asia, 14 percent in Africa, 10.1 percent in Latin America, 6.8 percent in North America and 6.5 percent in Europe (WHO, 1980, 1984).

In countries where the proportion of LBW is low, most of them are due to pre-terms (premature), while in countries, where the proportion of LBW is high, they are largely due to foetal growth retardation.

The Indian situation

Even within India the prevalence of Low Birth Weight in different regions varies amongst different communities. The percentage of LBW in urban areas varies from 22.0 in Pondicherry (Srinivas, et al, 1976) to 34.7 in New Delhi (Gosh et al, 1971). In rural areas it varies between 30 and 31 (Kumar, 1981).

Index of Risk

The prevalence of low birth weight, prematurity, perinatal and neonatal mortality rates are quite high in developing countries. There is a strong association between birth weight and survival status of the infant. Low Birth Weight might be resultant of premature delivery of foetal growth retardation. Also LBW and prematurity are important causes of perinatal and neonatal mortality. The birth weight is normally recorded in all hospital deliveries, while it is not observed in all home deliveries, causing deficiency in data base. Special studies have shown that weighing at birth is also possible in rural home deliveries.

Considering the above factors, it is feasible to have LBW or perinatal/neonatal mortality as the appropriate Index of risk.

If the notion of risk is understood clearly, the chance of reducing the undesirable outcome is high, provided the expected action is taken at the appropriate time. The assumption of risk approach is that as the knowledge increases the unforeseen events will become fewer and fewer. But it is to be remembered that not all events can be identified and chance still plays a role. It is possible to estimate how many would experience the defined outcome such as Low Birth Weight, or perinatal or neonatal mortality in a given period but it is not possible to predict which mother will experience the defined outcome.

Prevention of low birth weight

Risk approach aims at identification of women who are at risk of experiencing the defined undesirable outcome. The identification of the risk factor can be done at two physiological status of women, viz.

a) Non-pregnant and Non-lactating (NPNL).

b) Pregnancy: Here, the aim is to prevent the risk of LBW. The risk factors that can be identified, for the women of NPNL stage are,

a) Age; b) Parity; c) Birth interval, and d) Previous obstetric history.

Teenage Pregnancy

It is observed that teenage women are at higher risk of delivering LBW infant than women of any other age-group upto 35–39 years. Teenage pregnancy can only be postponed by counselling and effective implementation of age at marriage. It is the education of women rather than the legislation on age at marriage, which would help to reduce percentage of high risk women.

Parity

Since primiparous women are at higher risk of delivering LBW infant, nothing can be done, since the event has to be gone through. The only advice that can be given on regular antenatal visits is to deliver in hospital/institutions.

Previous Reproductive Loss

Since the relative risk of LBW is higher for components of obstetric history like Intra-Uterine Death, Prematurity, neonatal death, more attention has to be given to those women, while monitoring for current pregnancy.

Identification of risk, during pregnancy

The risk factors for pregnant women are: a) current antenatal complications; b) Weight gain during pregnancy; c) Monitoring for haemoglobin levels; and d) Fundal Height and Abdominal girth.

Effect of Supplementation of food

Various studies have shown that there is significant increase in mean birth weight, when there is food supplementation during pregnancy. Supplementation throughout pregnancy poses many practical problems, as three per cent of the population is always in the pregnancy stage. Since the maximum intra-uterine growth occurs in last trimester, one can think of effective implementation of supplementation in the third trimester. The existing supplementation programme viz., supplementary nutrition programme (SNP) and Integrated Child Development Services (ICDS), should be strengthened to facilitate smooth supplementation to pregant women.

Monitoring for antenatal complications

The antenatal care has got far more beneficial effect on birth weight. A minimum of eight antenatal visits with atleast four visits after 32 weeks of pregnancy, would be taken as adequate (NIN Annual Report 1982). The components of antenatal care for monitoring risk are (a) weight gain (b) rise of blood pressure (c) identification of obstetric problems like twins, Hydramnioes (d) Fundal height and abdominal girth.

The above components of antenatal complications have to be repeated for each visit to categorise women into high/low risk group.

Monitoring for weight gain

It is very difficult to get pre-pregnant weight, as women register for pregnancy only after 20 weeks. Unless and until women have regular antenatal check-ups, it is very difficult to monitor for weight gain. If the weight gain is less than one kg. than the previous visit, the women enters into the high risk category.

Monitoring for Haemoglobin level

One Haemoglobin value done at 20 weeks is sufficient to detect severe grades of anaemia, which is associated with LBW.

Fundal Height and Abdominal girth

The fundal height and abdominal girth are highly correlated with birth weight. They are useful indicators to assess IUGR. The two indicators would help categorise women to screen for the high risk group. Fall in fundal height and abdominal girth to lower percentile values than that which were observed for each period of gestation is an indicator of risk.

Apart from identification of risk factors, the following needs to be considered for the proper management of LBW problems.

a) The reproductive health must be considered in a larger context and many disciplines involved in the planning and implementation of health care.

b) Failure in delivering proper care is mostly due to poor organisational facilities and lack of proper communication.

c) Right knowledge through proper education in reproductive health is essential for successful handling of the problem of LBW.

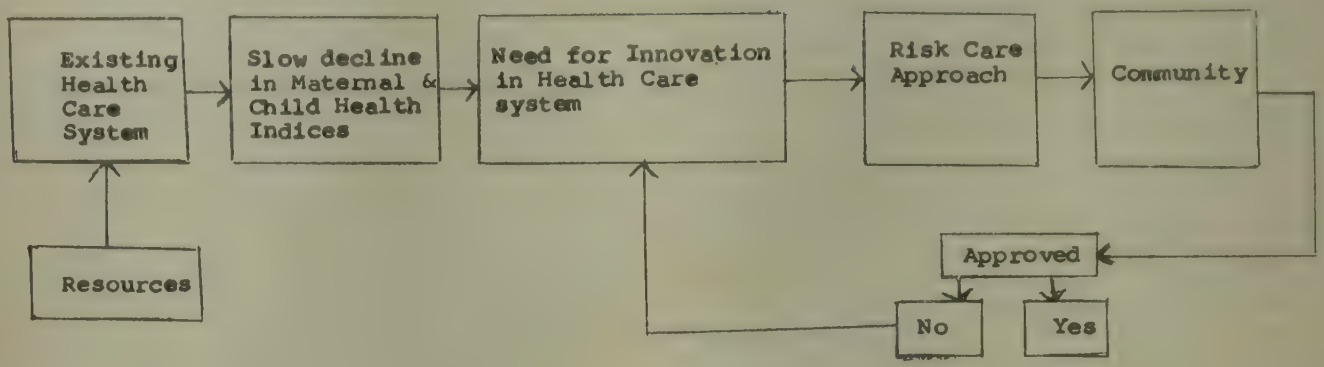
d) There is no data base at the national level on birth weight and birth weight specific mortality. It is of paramount importance to have centralised data base on these two vital aspects.

The usual recording of birth weight can be easily introduced in different project areas in India. For instance it is feasible to introduce recording of birth weight in project areas of Integrated Child Development Services (ICDS), which covers 10

percent of the Indian population. Thus the proposed data base on birth weight and birth weight specific mortality can be on the lines of:

a) Sample registration system of births and deaths.

b) Model registration system of causes of death. published by the Registrar General of India.



FLOW DIAGRAM - 1

NEED FOR INNOVATION IN THE EXISTING HEALTH CARE SYSTEM

How to Say Good-bye

Saying good-bye as you leave your children with a new care-giver or school may tug at your heartstrings, but you can put the "good" back in good-bye and ease difficult transitions.

Prepare yourself

★ Talk with other parents who have dealt successfully with similar transitions.

Prepare your child

★ Play hide and seek with infants to help them begin to learn about separation.

★ Use occational substitute care before the big day. Take toddlers or older kids to the new place ahead of time.

★ Show them bathrooms, classrooms, play areas; let them meet the teacher.

★ As the big day approaches, stick to familiar, comforting routines, such as bedtime stories. Establish new routines for the transition: Let your child help pick clothes or pack lunch.

★ Let your child take a favourite toy or a picture of the family with him.

★ On the way there, discuss what you'll do together at the end of the day.

★ Never, ever leave without saying good-bye directly to your child and assuring her that you'll be back.

The reunion

★ Bring a snack for your child to have on the way home.

★ Don't be surprised at your child's reaction. Some children, even infants, may ignore parents or refuse to leave instead of greeting them joyfully. Departing routines-packing up belongings, putting away playthings-help.

★ Allow children their own time and ways to adjust.

★ Make a decision to put all else out of your mind and spend time with your child when you are reunited. After being apart all day, you need each other.

— Parents

Your new born baby

Dr K R Antony, MBBS, DCH, DTCH

What a joy you feel when you first hear the cry of your baby! After hours of bearing down, anxious moments and uncertainty of what is going to happen you are finally relieved. It is all over! You have done it!!

Your husband and relations waiting outside are also relieved and happy. He is a proud father. This baby is the fruit of your happy married life.

Though there are many other babies in the hospital or in the house your baby is somebody special. Because it is yours!

You see the baby, you gently touch it, feel it and hold it in your arms.

I would like to point out to you certain observations you will make at this juncture. Some are normal for a new born. Some are harmless variations from the normal. But some require continued monitoring by medical experts.

Cry:

A healthy baby will cry vigorously as soon as it is born. The cry will be feeble and weak in a premature baby or in a term baby who has undergone suffocation. Crying is one way of expanding lungs and taking atmospheric oxygen into its tiny air sacs.

When the baby is born and when the umbilical cord is cut its lifeline with the mother is cut. This lifeline inside the womb had provided nourishment and oxygen and carried impurities from its circulation to be cleared by the kidneys of the mother. So the moment the umbilical cord is cut the new born has to activate its lungs, heart and kidneys fully.

If the baby does not cry and tries to breath on its own no oxygen will be inhaled. The blood flowing to its brain will be saturated with carbon dioxide instead of oxygen.

More than five minutes lack of oxygen to the brain will lead to the death of the brain cells. This brain damage can be permanent and the result will be mental retardation as the child grows.

Colour:

If the baby had undergone suffocation during labour it will be blue in colour instead of rosy pink. Pink colour reflects adequate oxygen in the infant's circulation whereas blue is due to the high level of carbon dioxide. So it is important that your baby is not blue especially over the tongue and inside the mouth even after five minutes of birth.

Reflex movements:

A suffocated baby will be very limp. Whereas a healthy infant will be very active, its hands and legs will move around a lot. It will grimace or cry on stimulation, like flipping on the sole. This reflex response to irritation is very poor in a suffocated baby.

Initiating breathing:

So in a blue, limp baby, which is not crying, the most urgent need is to establish its airway and initiate breathing. Some secretions which may have pooled in the throat has to be sucked out. The head has to be bent backwards so that the neck stands out forward. A few gentle compressions over the lower chest wall might initiate breathing movements. At times the doctor has to pass a tube through its windpipe and supply oxygen for sometime. (Intubation) During home deliveries and when intubation experts are not available a simple procedure like mouth-to-mouth breathing can be done. A birth attendant can blow gently from his/her puffed cheeks into the mouth of the new born baby. This timely act can prevent lifelong mental retardation.

Temperature maintenance:

Once the breathing is established the next important thing to do is to keep the baby warm. Inside the womb it enjoys the warmth of its mother's body fluid. This temperature may be uncomfortable for us to bear but the baby enjoys it. If the infant is exposed to cold its body has to burn up a lot of glucose to generate energy. This exhausts the baby. To prevent this a baby has to be wiped dry and wrapped in a soft cloth. In cold season it is advisable

to have a spotlight with 25 watts or 40 watts bulb 1 foot away from the baby. In a preterm (less than 37 weeks of pregnancy) baby it's all the more important to maintain the temperature. In a hospital nursery such babies are kept in an incubator which will artificially maintain a set temperature and humidity. In village homes such babies can be kept close to the chest or tummy of the mother by a cloth-sling. In Bogota (Latin America) preterm babies are found to survive in these chest-slings of the mother which is as good as incubator care.

mother against leaked out blood cells of the baby will later on cause breakdown of infant's red blood cells. This is called Haemolysis.

If the intensity of the jaundice is very high, it can cause certain irreversible damage to the brain. The Bilirubin when deposited in the brain will give rise to mental retardation, learning disability, hyperkinetic movements and rigidity of the limbs. One way of removing an unacceptably high level of Bilirubin is to remove the infant's blood and replace it with normal blood of the same group. This process is called exchange transfusion.

It is important that the parents check with a paediatrician whether the baby's yellow colour is within normal limits or not. Even if the jaundice is pathological it can be solved by expert management, provided the baby is transferred to safer hands.

Activity:

The next observation parents must make is the activity of the baby and the most important activity is

So in a blue, limb baby, which is not crying, the most urgent need is to establish its airway and initiate breathing. Some secretions which may have pooled in the throat has to be sucked out. The head has to be bent backwards so that the neck stands out forward. A few gentle compressions over the lower chest wall might initiate breathing movements. At times doctor has to pass a tube through its windpipe and supply oxygen for sometime (Intubation).

Jaundice:

Another colour change of the new born to be taken seriously is a deep turmeric yellow colour. A mild yellow colour on the third to eighth day after birth is a normal variation. This is due to breakage of excess red blood cells and a pigment released into the blood stream called Bilirubin. This pigment will be excreted by the kidney after some chemical processing by the liver. As the immature liver cannot cope with the extra work load, this backlog of Bilirubin circulating in the blood stream will give a yellow colour - Jaundice in the new born.

What the parents should be alarmed about is the deep yellow colour even at birth or within 24 hours. If the mother's blood group is "Rh negative" and if the baby is "Rh positive" there can exist a blood group incompatability. Antibodies developed in the

sucking. The movements of the limbs is the next. If the baby is vigorously sucking at the breast it is a healthy baby. If it was sucking well initially but later on becomes a poor sucker, a doctor must see the baby to find out what happened. Correspondingly active limb movements becomes slower and sluggish. This can be due to dangerous conditions like sepsis in the newborn, infection of the brain coverings called meningitis or even pneumonia. Here again appropriate antibiotic therapy, intravenous fluid support etc. will save the baby.

Urination and defeacation:

Has the baby passed urine and motion? This is a constant query made by attendant mothers, sisters-in-law or any other relations. Some babies pass the dark green first stool at the time of birth. But others will do it after taking in some amount of breastmilk

or swallowing atmospheric air into the gut. In any case when the stool is passed we can be assured of the patency of the gut. If no stool is passed and the abdomen is bloating up and the baby is vomiting, then a serious structural anomaly in the gut has to be suspected. A paediatric surgeon may have to investigate your baby.

Urine is passed normally within 24 hours. During summer season when the newborn baby looses considerable amount of fluid from the skin surface, the urine output will be less. In such babies, urination might be delayed upto 48 hours maximum. But beyond this time gap if the baby is failing to pass urine, a congenital anomaly of the urinary system has to be doubted.

Convulsions:

A traumatising experience for any mother is to see her cute little baby convulsing. Though rare, if it happens, a doctor's attention and investigation is necessary. If the baby is active and feeding well in between convulsions, it is likely to be due to some metabolic derangements. eg. lack of glucose, low level of calcium, etc. Some convulsions may be due to the transient changes occuring in the brain as a result of suffocation at birth or even some bleeding into the skull. A bacterial infection of the brain causing convulsion is more serious. Here again timely expert management is needed. Continued frequent breastfeeding is a must to maintain the blood glucose level and hydration of the baby.

Bleeding:

Bleeding of the newborn is another variation which will upset the mother. Some babies may bleed from the vagina on the second or third day almost like menstruation. The quantity is very small and it is absolutely harmless. It will stop on its own. The reason is that the baby's blood had a higher level of sex hormones from the mother. The moment the umbilical cord is cut, this level starts dropping which results in a withdrawal bleeding just as in menstruation. No medicine is required for this.

Some other babies bleed from the nose, mouth, umbilicus, any injection marks etc. This can be due to lack of vitamin K or other coagulation factors. One dose of vitamin K injection brings about dramatic improvement if it is due to deficiency of that vitamin. Other babies might require fresh blood transfusion and expert management.

Caput and Cephalhaematoma:

The face of your baby may look a bit puffy and the head may be a little elongated and uneven. This will settle down to normal in a day or two.

When you feel the head of your baby immediately after birth, it appears very soft and pliable. At the back of the head some babies will have a boggy swelling. This is due to some fluid which has oozed out into the scalp as a result of prolonged compression on it at the mouth of the birth canal. This is very transient and will be absorbed in a couple of days. It is called Caput by the staff in the labour room.

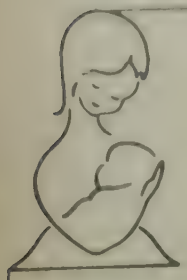
There is still another soft boggy swelling of the head restricted to a particular area of the skull. This is called Cephalhaematoma. It appears on the second or third day unlike Caput and disappears only by three to six weeks time. This is due to a little bleeding under the outer layer of the skull bone when it is squeezed through the birth canal. Here again no treatment is required. No massaging or compression is advised while giving bath to the baby.

Breast nodule:

Most newborn babies will have a breast nodule. It is a sign of maturity. But there can be a variation in some babies. This nodule can increase in size, become tense and a watery secretion may ooze out. It is due to the influence of sex hormones of the mother. It subsides in two or three weeks time and should be left alone. Some try to squeeze it, foment it and massage it during bath. This should be discouraged.

Mongolian marks:

Have you heard of Mongolian marks? Paradoxically it has nothing to do with Mongolism or Down's syndrome which is a kind of chromosomal abnormality resulting in mental retardation. Mongolian marks are bluish marks on the buttocks and back at birth. It may also be seen at times around the wrists, knees and ankles. It is absolutely harmless and gradually disappears in a few months time.



Naevi:
Naevi seen in some babies are pink to purple looking patches which may either be raised from the skin or not. Some varieties disappear gradually while others do not. Some do have profuse hair on it. Let a doctor advise you later about its nature and if any cosmetic surgery is required. Right now it should not worry you.

Vernix:
When your baby is handed over to you its skin may be covered with a sticky white material especially in the groins, under the armpits and around the neck. It is called vernix. It is not any 'dirt' to be removed meticulously. On the other hand forceful removal of the vernix may injure the skin and predispose it to infection. The vernix gives some protection against skin infections. It dries up in a couple of days.

Club foot:
Some amount of inward curving of both feet is a normal variation. It will be straightened up after a few days. But severe club-foot requires splinting and management by a bone specialist.

Umbilical hernia:
Swelling of umbilicus while crying or straining for defeacation and urination need not worry you. Most of them disappear spontaneously by the age of one and a half years to two years. Only if it persists beyond this period is a surgical intervention required.

Hydrocoel:
Swelling of the scrotum if noticed can also disappear during the first one year. No need to hurry to excise it.

Eye discharge:
Some amount of discharge from the eye during the first week disappear spontaneously by just cleaning two or three times a day with a swab soaked in boiled cooled water. But if the discharge is thick, eyelids congested and red, vigorous antibiotic drop irrigation is required.

Thrush:
A white coating of the tongue and inside of the mouth is seen in some babies. This oral thrush requires application of antifungal agents.

Sub conjunctival haemorrhage:
Some babies will have a red blood patch over the white of the eye ball. It is due to bleeding into the conjunctival covering of the eye ball which will get absorbed in a few days time. No medicine need to be put in the eye.

Skin changes:
Peeling of the skin of the baby is another worrying problem. It can occur in some normal newborns and in most of the post mature babies (born two weeks after expected date of delivery) Nothing needs to be done.

Some babies on the 2nd or 3rd day develop discrete, reddish rashes over the face, chest and back. Occasionally small vesicles develop on the top of these rashes. These rashes, called Erythema toxicum, disappear spontaneously and do not need any treatment.

Birth weight:
A normal newborn baby will weigh between 2.5 to 3.5 kgs. Some bigger babies are babies born to diabetic mothers, in which case, they require extra glucose feeding to prevent convulsions.

Babies born with low birth weight may be either preterm (less than 37 weeks of gestation) or small for their period of gestation. In either case, they require special attention with regard to feeding and temperature regulation. It is better such babies are seen by a paediatrician and kept in a special nursery, if he feels it necessary.

As a mother, any abnormal structural features of the limbs, head, chest, abdomen spine and buttocks that you notice, should be brought to the notice of a nursing sister or the doctor for their expert evaluation.

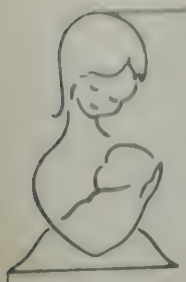
The ecstasy of becoming a father or mother can be marred by the nagging worry of some normal variations. This can be avoided if parents are enlightened about those variations. On the other hand certain dangerous signs if ignored by a complacent mother due to ignorance can take away the joy of possessing a new born baby.

The beauty of the gift of God of a 'normal' baby is seldom appreciated by many till they see how things can go wrong.

Save your baby — Breast feed:

For nearly 2,740 babies per day, breast milk deprivation proves fatal.

Breast feeding is the best thing that can happen to your baby.



At the individual level, it promotes optimal physical and mental health.

At the community level, it dramatically reduces the incidence of

a) Malnutrition
b) Infection
c) Unregulated fertility

This single measure alone can save the national economy millions of rupees a year.

II. PRACTICAL WAYS TO ESTABLISH BREAST FEEDING

1. Antenatal care:

Prior to the birth of the baby, the mother should be spoken to about

a) The advantages of breast feeding and the minor problems she is likely to have in the initial stages. This will help her prepare psychologically for breast feeding.

b) Massage of the breast and areola to loosen up any areas of tightness and to thicken the areolar skin.

c) Proper nutrition, rest and avoidence of habits like smoking, and excessive consumption of caffienated drinks.

Inverted or retracted nipples need medical attention antenatally.

2. Timing

The baby should be put in the naked state on the mother's chest as soon as it is born. Breast feeding should commence within half-an-hour of delivery.

3. Rooming in

The baby should be roomed in with the mother for 24 hours in a day.

4. Frequency

In the early days, frequent sucking will help promote breast feeding. Subsequently an interval of 2-3 hours is recommended.

Demand feeding should be encouraged.

5. Duration

The baby should suckle at both breasts. There should be complete emptying of at least one breast. The duration on each breast should be approximately 10 minutes. The baby should be exclusively breast fed for three to four months. Partial feeding from the breast can continue for upto 2 years.

6. Method of sucking

The baby should take the entire areola in its mouth. Sucking only at the nipple will not ensure adequate milk.

7. Allow the baby to breath

The nose should be kept clear of the breast to ensure free breathing during feeding. The nose should also be clean. A blocked nose can lead to poor feeding.

8. Taking off

When the baby completes feeding, suction should be released by inserting the mother's little finger between the areola and the baby's mouth.

9. Burping

Soon after feeds the baby should be burped. This is done by holding the baby on the shoulder and tapping on the back. Subsequently the baby should sleep on the side or on the stomach.

10. Position

Any position that is comfortable to the mother is acceptable.

11. Final Word

Breast feeding is not a forced activity. It should be done in pleasant setting. The mother should be encouraged in her efforts especially by her husband and elders. Support from the nursery and medical staff is very important.

Some Dont's

Do not Worry about capability of feeding. All mothers can.

Do not Feed sugar water, or any other feeds prior to starting breast feeds.

Do not Use bottles ever.

Do not Use pacifiers.

Do not Clean breasts apart from regular bathing.

Do not Listen to neighbours, and relatives who pass comments on how thin the baby is or how much the baby cries. Check any doubts with your doctor.

Do not Stop feeding because of minor illness/ common medicines etc. Even in serious illness, consult your doctor.

III. COMMON PROBLEMS

In general most problems with breast feeding are due to the mother's anxiety. Reassurance is all that is needed.

a) Inadequate milk

This problem is commonly encountered in three situations.

i) In the first few days: Reassurance that colustrum or early milk is adequate during the early days is necessary.

ii) Between 3rd and 4th week when the supply of milk matches the baby's requirements. The feeling of heaviness of the earlier weeks is not there and some mothers interpret this as inadequate milk. Reassuring them is all that is needed.

iii) Mothers have a tendency of interpreting any symptom in the baby, as a sign of less milk. Adequacy of milk should be assessed only by weight gain and the general health of the baby.

b) Stooling pattern

The second major concern of the mother is the stooling pattern, complaints are usually...

a) Frequent stools

b) Infrequent stools

c) Stools soon after feeding

d) Green colour of stools

Mothers should be reassured that a normal baby may pass 10-15 times per day or once in a week, both are normal. Passing stools soon after feeding is also quite common and does not mean indigestion. Some breast fed babies may pass green motions under healthy circumstances. The emphasis again should be on weight gain and not on stooling pattern.

c) Irritability

Fussiness or crying is the third common problem which mothers have. They commonly interpret crying to inadequate milk. Common causes of crying include —

i) Minor problems in the baby — nasal blocks, bottom sore, wet diapers, minor illness etc.

ii) Problems in feeding: Frequent feeds, infrequent feeds, occlusion of the nose during feeds, nasal block, retracted nipples, sore nipples, failure to burp etc.

iii) The need to be picked up: when a baby cries she should be picked up and fondled. If she quietens she does not need to be fed. The baby needs attention and tender care as much as milk.

d) Vomiting

Some babies bring up a little milk after feeding. This is called possetting. This is perfectly normal. Proper burping and reassurance is all that is needed.

e) Sore nipples

These are usually caused by

i) Too frequent feeds

ii) Prolonged feeding

iii) Failure to release suction

iv) Improper care of the nipples — use of strong soaps.

v) Fungal infection of the baby's mouth.

Use of bland cream and proper management of feeding will resolve these problems. Temporary expression and feeding will also help.

f) Retracted Nipples

Retracted nipples should be managed before the birth of the baby. After delivery, backward pressure on the areola will make the nipple protract. Nipples shields should be used as a last resort.

g) Mastitis/Engorged breasts

This usually happens when the breast is not emptied out

Common causes are ...

i) Painful feeding Due to sore or cracked nipples

ii) A low birth weight or sick baby who cannot suck well

iii) Physiologically between 5 to 10 days when milk flow is more.

Here again, prevention is better than cure. Regular emptying of the breast by expression should be encouraged. The expressed milk can be fed to the baby.

h) Some occassional problems:

i) Will breast feeding alter the shape of the breast? — No

ii) Do small sized breasts produce less milk than large size breasts? — No

iii) Will breast feeding help in weight reduction ? — Yes, combined with proper diet and exercise.

iv) Will the baby get addicted to the breast ? — Yes, if proper weaning is not commenced between 4 to 6 months of age.

v) Does weaning mean stopping breast feeds? — No, it means gradual introduction of foods commonly used at home. Breast feeding should continue.

IV. BREAST FEEDING UNDER SPECIAL CIRCUMSTANCES

1. Twins: With some assistance a mother can feed both babies at the same time. Milk will be produced in adequate quantities for both.
2. Premature babies: Breast milk should be expressed and fed to these babies as soon as they can tolerate oral feeds.

Sucking at the breast should be encouraged at the earliest.

3. Sick babies: Mothers of the babies should be taught to express milk regularly so that the production of milk continues. The expressed milk can be used to feed other babies. Breast feeding should be started as soon as the baby is well.
4. Working mothers: Breast feeding should be encouraged when the mother is at home and on holidays. Milk can be expressed and stored in the refrigerator and fed to the babies during the mother's absence. Top feed should be kept to the minimum. The bottle should never be used.

At work the mother should express out her milk and discard preferably every 2-3 hours. This helps in preventing engorgement and in maintaining the flow of milk.

CONCLUSIONS:

Breast feeding is the best for your baby.

If you cannot breast feed express the milk and give it to your baby or donate it to a breast milk bank.

The only way of knowing whether breast milk is sufficient or not is by regular, accurate weighing of the baby.

None of the common illnesses and medicines are contra-indications for breast feeding.

Minor problems are frequent; they are there only to be overcome.

Above all every mother can breast feed her baby and this is the best gift that her new born deserves.

EXPRESSING BREAST MILK

Expressed milk can be a boon to a premature or sick baby; it can be stored in a breast milk bank and used when necessary. As manual expression is commonly used, the technique is briefly explained.

1. Antenatal preparation on the correct technique of expression is helpful.
2. Psychological support – most mothers of sick or premature babies are distressed. Support from relatives and medical staff is important. The knowledge that the expressed milk is being fed to her own baby makes the mother-baby bonding stronger.
3. Hand Washing — with soap and water, prior to expression should be insisted upon. Nails should be trimmed and clean.
4. Stimulate the milk ejection reflex. Ensure a calm and quiet atmosphere. A warm bath, a non caffienated drink, gentle massage of the breast and back, and skin contact with the baby help in eliciting the reflex.
5. Place the thumb and two fingers perpendicularly across the aerola. The distance between the two should be approximately 6 cms. Movement should be towards the ribs and roll over. The aerola and breast should not be squeezed: this will lead to pain and inhibition of milk production. The distance between the thumb and fingers should remain constant at all times.

   Keep moving the thumb and fingers across all the sectors.
6. Express each breast for 3 to 5 min. at a time.
7. Effective manual expression takes atleast 20 min.
8. Frequency should be atleast 8 to 12 times a day.
9. Collect the milk in a sterile wide mouth container. Milk tends to spray in all direction which can be collected easily in a wide mouth container.

BREAST MILK BANKS

Like blood banks, breast milk banks collect, store, and distribute breast milk from healthy donors.

Donors are screened for disease and only milk from healthy donors is collected.

Milk is collected in sterile vessels and stored in freezers.

The milk is thawed, tested, pasteurised and used when needed.

Kangaroo mothering

"Separating a baby from its mother is a major professional crime." Dr. Edgar Sanabria Rey, Kangaroo mothering programme co-ordinator at San Juan de Dios hospital in Bogota, Colombia said, "Sometimes it is not our economic but out intellectual underdevelopment which prevents us from proposing and implementing our own solutions to our problems as well as sharing with others".

The programme of Kangaroo mothering was developed from the thinking that what is good for a kangaroo might be good for human infants. All kangaroos are born premature and are protected in the mother's pouch — deriving all the needed warmth (instead of the incubators recommended for premature babies). Doctors thought: can we make a pouch on a human mother? Babies might react similarly.

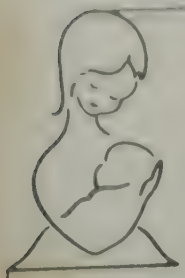
The programme has many advantages:

1 close bondage is created between mother and baby

2 more premature and underweight infants survive

3 cost is reduced; mother replaces the incubator

Based on a news item in "Action for children", New York, No. 3, Vol. 3, 1988.



Jaundice in the Newborn

Katherine Karlsrud with **Dodi Schultz**

For the average person, the word jaundice carries alarming connotations. This yellowish tinge to the skin and whites of the eyes is typically associated in adults with a serious liver infection, hepatitis.

If may come as a surprise to learn that some jaundice occurs in the majority of newborn babies. In most cases, it's physiologic jaundice – jaundice connected with a normal physiological process.

Waste disposal. Before birth, all oxygen needed by the baby-to-be is routed from the mother's blood-stream, through the placenta. To assure adequate distribution of this limited supply, the fetus creates an extra supply of red blood cells.

Once the baby is born and breathing, there is plenty of oxygen available. The extra red cells are no longer needed, and the body commences destroying and discarding the unneeded cells.

Among the waste products of that process is a yellow pigment called bilirubin, which is metabolized by the liver and excreted. The baby's disposal mechanisms may not be operating as efficiently as they should (especially likely if birth was premature) and can't quite keep up with the workload; poor initial feeding, with low fluid levels, worsens the problem. Some of the pigment "backs up"-specifically, into the skin (usually first in the face, spreading downward) and eyes. The result: jaundice.

Threat and therapy. If this "normal" jaundice reaches full body length, body fluids must be supplemented, blood levels of bilirubin will be regularly monitored, and the infant will be carefully observed.

The reason for these precautions is that if the visible repositories (skin and eyes) are exhausted, the pigment heads for the central nervous system, causing a condition called kernicterus, which can lead to brain damage. That outcome is completely preventable, in most cases by phototherapy: If bilirubin levels continue to climb, the baby is placed under special lights that convert the pigment to a harmless substance. In very rare instances, a blood transfusion may be necessary.

Perhaps 1 of every 15 of my newborn patients evidences enough of this "normal" jaundice to be closely watched and repeatedly tested. But only 1 or 2 in a 100 have required phototherapy.

Not so normal. It should be noted, for the sake of completeness, that jaundice in the newborn period can also be due to other causes, either more or less serious than the common condition I've described.

Physiologic jaundice generally peaks on the second to fourth day of life. Jaundice appearing during the first 24 hours means an emergency situation: It may signal the activity of hemolytic antibodies that are attacking and destroying the baby's red blood cells, typically due to conflicting mother-baby blood or Rh groups.

The physician will already be on the alert, since a Coomb's test, routinely performed at birth on blood from the umbilical cord, will have revealed the antibodies' presence (which means only that watchfulness is called for). If the baby is clearly in difficulty, immediate treatment is instituted.

Finally, there is an unusual condition-it affects an estimated one in 200 babies-we call "breast-feeding jaundice". There is a naturally occurring chemical in some mothers' milk that seems to interfere with their babies' efficient processing of bilirubin. Jaundice due to this phenomenon generally starts between the fourth and seventh days after birth; it can last for several months.

Of course your doctor must check the baby to rule out other possible causes. If it does turn out to be ordinary breast-feeding jaundice, you should know that it is not considered serious, no treatment is needed, breast-feeding can usually be continued (a brief respite may be advised) and the baby will thrive.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

The death trap for little girls: Female foeticide

Janaki Murali

Having declared 1990 as the year of the girl child, SAARC has spotlighted the peculiar problems facing the girl child in the Asian countries. Female foeticide and infanticide are two death traps that await every girl child daring to be conceived, leave alone to be born. Foeticide is prevalent mostly in the Asian countries and to a lesser extent in Africa and South America. The developed nations, with their higher degree of literacy, naturally do not have female foeticide and infanticide listed as one of their problems.

Most developing nations show a disturbing tilt towards the boy with the male/female ratio becoming imbalanced. The accepted international norm is 106 males to 100 females. The U.S.has a ratio of 104.7 boys to 100 girls; Japan has 105.4 boys to 100 girls. Singapore and Hongkong show no significant disparities, probably because of the absence of sex determination tests in these two places. South Korea has 108.1 boys to 100 girls; and China 108.5 boys to 100 girls.

The Korean Medical Association, few years ago imposed a self regulatory ban on SD (Sex Determination) tests, the doctor or clinic guilty of carrying out such tests would be fined heavily and their medical licence would be suspended for three years. China too strictly forbids prenatal testing, although it is being practised on the sly. China's one child policy, led unscrupulous parents who had a daughter born to them, to immediately snuff out its life by either poisoning or strangling or even drowning it, so that the parents could have another go at having a male child. In the later eighties, the law was relaxed a little to allow families to have a second child after a four-seven year wait. Infanticide is considered a serious offence in China and parents who attempt it are subjected not only to censure and scorn but also to imprisonment.

To safeguard against female foeticide, Chinese medical authorities in 1986 asked doctors using amniocentesis and ultrasonography to vow that they would not tell the parents the sex of the unborn baby. However compliance of the rule is difficult to monitor.

In India the ratio of girls has dropped to an alarming low of 933 females to 1000 males as per the 1981 census and continues to drop. Statistics show imbalanced sex ratios among children in one-third of India's 326 rural districts. Concerted campaigning by

activists led to a ban of sex-determination or SD tests in Maharashtra, where doctors and quacks were promising the moon to prospective parents. Advertisements regarding where a SD test could be done, were even appearing in the local trains of Bombay. But the Maharashtra government's quick action in banning SD tests may not have succeeded in stopping the practise altogether, it may have only ensured the practice going underground, with unscrupulous doctors resorting to SD tests for a higher price. A ban of SD tests at the national level is what activists are aiming for, but will a ban alone be enough? Certainly not. The ban can succeed only if the government and government agencies, voluntary organisations and concerned individuals take up the issue and ensure its implementation.

The other word for sex determination test is aminiocentesis, which in short means extracting 15 cc of amino fluids from the womb to determine the sex of the foetus. The SD test is usually performed in the 14th or 15th week of pregnancy. The technique of amniocentesis was originally developed for the detection of over 70 genetic diseases, most of which are serious, by direct chromosonal study of foetus cells. Sex determination by chromosome analysis was done when a sex-specific disease was considered possible and where no other pre-natal test was available. One example is heemophilia or Duchenn muscular dystrophy, where the mother may be a carrier of the disease, but can affect the child only if it is a male. In such cases, if the male is detected, the doctor/patient has the option to abort the foetus.

So, foetal sex determination originated as an offshoot of an important and useful clinical tool, but in the last eight years or so, it has become a ghastly tool with which to exterminate the female foetus. A study in Bombay of 8000 cases of abortion showed that 7999 of them involved a female foetus.

Aminiocentesis can cause damage to the foetus and placenta, resulting in spontaneous abortion and premature labour. It can also create problems like hip dislocation and respiratory complications, and needle puncture marks on the baby. Then there is the risk of infection in the reproductive tract if aseptic procedures are not strictly adhered to during incision and piercing of the amniotic sac. A study of 242 cases conducted by the Voluntary Health Association of India states that the chances of premature delivery are four percent, a fact not mentioned by the doctors conducting the SD tests.

Abortions that follow a SD test when the parents gather that the foetus is of a girl has also its own hazardous implications. The test is usually performed in the 14th and 15th week of pregnancy which means that the abortion is done in the second trimester, which could be very dangerous and risky for the mother. Then we have the fact that more than 70 percent of our Indian women are aneamic and mal-nutritioned. A spate of abortions of the unwanted female child, could only aggravate the already high rate of maternal mortality in India which at 400-500 per 10,000 live births is considered the second highest in the world. Then there is the chance of infection to the reproductive tract and damage to those foetus that are retained.

Some doctors practising aminiocentesis have advocated that this could be an effective family planning tool and that couples would stop reproduction as soon as they get a male child. But they couldn't be further away from the truth. For SD tests do not gaurantee the birth of a male child. They merely ensure multiple abortions, which can as shown earlier only harm the mother.

In rural pockets and areas where the couple is unaware of the easy access of the SD test, female infanticide is widely practised. Girl babies are poisoned at birth by administering poison through the mother's nipple, or feeding the child grains of rice and letting the baby choke on it; leaving the girl baby to choke on her own fluids or just smothering her to death with a pillow.

Arguments are put forth by those doctors practising SD tests, that aminiocentesis will reduce the misery of women, that this would reduce the number of unwanted and neglected female children and an adverse sex ratio would according to the law of demand and supply elevate women's status in society and eliminate evils like dowry. How wrong could they be?

The girl child is expected to survive on next to nothing, fed on left-overs and always treated as

though she doesn't exist. She has to only reach puberty, to be married off. She becomes a workhorse to be even flogged into submission. While in her pre-married state, she has to submit to her father and brothers and often look after the home and younger children while her mother worked in the fields or as a domestic help;in her married state she often becomes the provider getting paid lesser than her male counter-part and producing children every year and caring for her in-laws and home too.

The mean age of marriage for women in India is 13.7 years and the age of conceiving between 15 and 35 years, according to a report on the rural areas of Andhra Pradesh. The scenario cannot be very much different in backward states like Rajasthan, Bihar and Uttar Pradesh. A village girl gets married at the age of 13-14 years and is then subjected to the drain of conception-SD tests-abortion-conception-SD tests-possibly a delivery and again the vicious circle of conception-SD test-abortion. Her best part of youth is spent as a reproductive machine. The stresses and strains of a tough life with the bare minimum of health services only paint a bleak picture for her.

Demographers suggest that having an adverse female sex-ratio could bring about the advent of customs like polyandry, sharing a wife, abduction, or purchase of women. It could also be argued that the adverse sex ratio may lead to an increase in the incidence of rape, prostitution and greater controls over women.

Statistics prove that rape and other atrocities on the girl child and child woman are only on the rise. As a recent report shows, Andhra Pradesh has the highest number of rape cases recorded. Nearly 1355 rape cases were recorded in the state, the figure jumping from 396 in 1986 to 448 in 1987 and reached 491 in 1988. The highest number of rape cases 132 in 1986-1988 was recorded in Guntur. East Godavari recorded 114 the second highest.

Critics may argue that this proves nothing, but consider the fact that science is only progressing, and better and safer techniques are being formulated for sex determination, which could only have dangerous portends.

a) Chrionic villi biopsy — is a method by which the villi of the chorion, tissue surrounding the foetus, is removed through the cervix. This tissue is tested for its sex. This new bio-technology enables sex determination between the sixth and 13th week. Abortion of the unwanted foetus will thus be carried out in the first trimester, with lesser risk.

b) Foetal cells in maternal blood-certain cells in the foetus, like lymphocytes can cross the placenta and enter the mother's blood. After the 10th or 12th week of pregnancy, if the blood is tested with the help of a flourescence activated cell sorter, it can indicate the sex of the foetus. This could make sex determination easy, quick and safe.

c) Sex determination among test-tube embryos — Recent experiments on mammals found that the whole animal can still be formed even if a few of the early divided cells are removed — this means that it is possible to take a few cells from the test tube embryo and test it directly. The remaining cells will be destroyed if found to belong to the undesired sex.

d) Other efforts are underway to separate sperm bearing chromosomes of a desired sex so that only these can be fertilised.

Thus as simpler and safer methods are evolved, late detection and abortion may no longer be associated with sex-determination tests. It will become very easy and simple to snuff out the life of a girl child even before her birth, in the safest medical and technical methods. The war against SD tests might then become more difficult, with critics finding it harder to convince people of the hazards involved. Hazards would then not be of a medical nature but purely of an ideological nature. The fact that empiral studies have proved a falling ratio of the girl to the boy could only result in undesirable customs and the rise of crime cannot thus be emphasised enough.

Rugged as the road demands

TVS-Suzuki AX 100R. With improved design features. An engine which gives **over 57 kmpl** under normal riding conditions. Sturdier front fork and strengthened rear suspension for **smoother riding.** Reinforced steel frame for **impact resistance.** Wider rims and tyres for **greater stability and road grip.** TVS-Suzuki AX 100R. The mobike for any road. For years.

Strap up your helmet for safety.

TVS SUZUKI

BUILT TOUGH TO LAST LONG

The Right to Life
The Right to be born

Patricia Palaparti

This article is not to outrage your delicate sensibilities! It's not to stir your wrath, nor even to flay your conscience. It is just a factual account of life — of life at its stirrings, at its very foundation, at its inception.

If you are reading this article, know then that you are the recepient of the most treasured gift from your parents... the right to be born. Should this have been denied you, all other rights — rights of the child or human rights would be meaningless, unnecessary.

For a long time now the world was divided on a very basic issue. Does the joining of a sperm and an egg mean that a new human person has begun the journey of life — or does it mean something else?

The baby's head was found in a dustbin. Aborted at 5 months, is this 'fetus' or human being ?

But let us seek truth. Seeking truth is the simple task of recognising what is actual, what is logical, what is real.

If you are still in tune with basic biology, you will say of course human life begins at the moment of fertilisation. That is the only logical, actual, accurate response. And, in fact the truth. And hence there should be no legal means to destroy human life — by chemical means or by the instruments of death.

Many years ago, people were not quite sure whether the unborn child was alive or at what stage of pregnancy it became alive. Today,however it has been proved beyond doubt that life begins at the moment of conception. This has been stated by the World Conference of Doctors, by the Geneva Conference on the Rights of the Child, and accepted by the United Nations in the declaration of Child's Rights (1959). The new technologies, like Foetology and Photoscopy, have pronounced it, as have many doctors of international fame (notably Dr. Micheline Michael Roth and Dr. Albert W. Liley, "Father of Foetology"). Medical journals, like California Medicine (1970), have carried it and experiments with test-tube babies have proved it. All up-to-date doctors today know that there is life in the unborn child from the very moment of fertilisation, and so do other enlightened people.

The war on children before birth is waged on a grand scale. And the killing of the innocent child who lives in the seeming security of her mother's womb has become, as one woman recently said, "just as easy as having a tooth extracted!"

Medical Termination of Pregnancy — MTP — a term which covers up the fact that human lives are being extinguished, is the popular and most easily available form of doing away with an innocent babe in the womb. Abortion is no longer a dirty word in a world so sullied with the blood and bones of the millions of lives snuffed out even before being born.

Murder — and 'murder most foul' is what abortion is all about. And who is the most responsible? The woman! The mother! She and she alone is the murderer. How compelled or by whom is a moot point. That she allows the murder of her innocent baby is what counts.

Today's urban woman feels she should have control over her body. She and she alone should be able to decide whether or not to allow her baby to live!

Ah! Woman! Why dost thou perpetuate a myth that thou art feather — brained and unfit to think and act rationally? Use the gift of your mind, sharp or oft times sharper than that of your male counter-part. Think. You talk of absolute control over your body. Do you really have that? When you allow the touch of a man to over-ride your control on your physical senses, what control are you talking about?

Is it only when you are faced with an unwanted pregnancy that you remember you have the right to control your own body? Is it only with the defenceless life within your womb that you can show the power of "body control." Should you not use that control positively? It is possible to find the ways and means of nurturting the life within you, of saying 'no' to abortion, whatever the circumstances.

It is often social and economic pressures which force a woman to resort to abortion — and thus women are denied dignity! Social and religious taboos and prejudices, lack of family support in cases of an unwanted pregnancy and inadequate enlightenment on what it entails, promotes abortion both legal and illegal. Our society as yet does not accept motherhood outside marriage. Hence society finds it easy to kill the tiny child in the womb!

A society where women are systematically discriminated against, where children are unscrupulously put to hard labour, where the poor are systematically oppressed and exploited — this society, will you allow this society to make a murderer of you?

As a woman, you have the right to know what goes on in your body when your child is growing inside you. You also have a right to know what abortion entails.

The bare bones of it all is simply this. A human being, albeit small and totally defenceless, is torn, tortured, killed.

Do you know how the baby in your womb feels? The baby, mind you! Oh! The abortion industry has had to invent its own terminology. You can't tell a

woman she is going to be chopping up her baby — she will probably change her mind. So a baby becomes a 'fetus', killing becomes a "procedure" and so on ad nauseam, while the abortion industry and its ancillary units churn up piles upon piles of blood-stained money.

Do you know what happens when abortions are done by the D and C (Dilation and Curratage) or D and E (Dilation and Evacuation) method? By this 'procedure' the abortionist uses large foprceps to crush the baby inside the mother's uterus and removes it in pieces and to be sure all pieces have been removed the abortionist (to lull his own conscience) asks "Is number four out? Is number one out?" Number one is the head of the child — other parts of the body are given other numbers!!!

Another 'procedure' used is saline in which a

This baby was aborted at 3 months by D & C method. Crushed to death and hacked to bits! Fetus ? Or baby ?

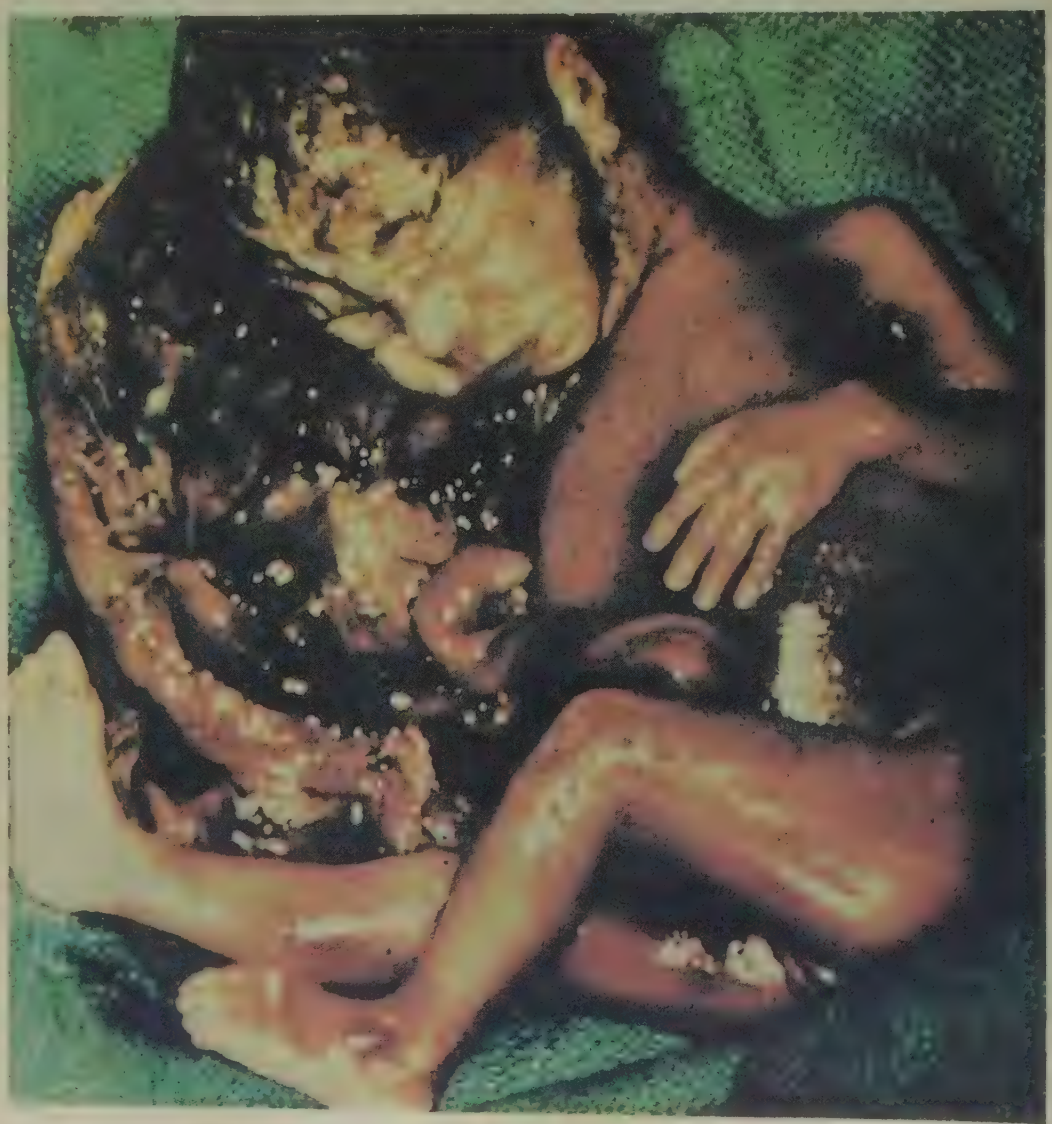
concentrated salt solution is injected into the mother's womb. The baby breathes in and swallows this poison. The salt causes extreme pain as it burns off the outer layer of the baby's skin, turning the baby red. Sometimes the baby thrashes about in the mother's womb for over an hour before it finally is aborted. Many saline abortions cause live births and the gasping baby is left to die or is disposed off in some other inhuman way!

In many of our state clinics wailing babies aborted at four-five months are left by callous doctors/nurses/dhais/sweepers to die in the buckets they have been thrown into. These hapless babies are usually food for prowling dogs, cats or rats!

Do you realize that a baby is human? Someone's flesh and blood? Perchance your very own? Not just a lump of flesh but a living baby who screamed in fear and pain while being 'killed'?

Have you heard the fetus scream mother? One doctor did — and gave up his abortion practice altogether. But having a fetus scream is rare. You need to have an air bubble hover exactly over the screaming mouth of the baby if you should be able to hear that scream.

But every baby that is torn out of its mother's womb opens its mouth wide in a silent scream of total



A burnt-up baby. Aborted by the 'Saline' method. Is there no end to murder ?

agony and terror. Do you know that mother? Do you know that the baby in your womb, when confronted with the probing instruments of death becomes afraid? The baby's normal heart-rate is about 140 per minute. But as soon as the death instruments enter the womb the heart rate swings upward to 200 and the baby sways violently away in terror. Do you know that mother?

Listen to what one mother who chose to abort her child had to say: "When my fetus was expelled for me, the realisation of what I had done overwhelmed me. I lifted the tiny little dead thing from the bucket that it had been flung into and placed it in the palm of my hand. I stood there for what seemed like an eternity, just staring at it. My god, I breathed, it looks like a HUMAN BEING! The little "lump of tissue" (current terminology) I held in my hand, had fingers and toes and a complete little female body, and — I've learned since then — a heart that had been beating and a brain that had been functioning. I also learned that my little daughter could feel pain and that she had suffered terrible torture and misery during the abortion. And suddenly I wanted to undo what I had done. I wanted to breath life back into the baby I had just killed... I realised, once the baby is dead, the woman's suffering just begins!"

What we need to know is that life begins from conception — and evolves into persons like you and me. Now is the moment to quit being the woman-murderer and become the woman mother.

Here's an open letter to parents from the fetus. You'll be surprised that the fetus is life.... and we have no right to end anyone's life, however tiny and defenceless that life may seem !

The unborn speaks...

Dear Dad and Mom,

Though I have begun to exist as an individual entity from the moment I was conceived, I have only been fully formed since the 12th week of pregnancy. If I could talk to you, mom, and to you dad, there are so many things I would tell you. Things that would make it easier for all of us. My task is to grow and mature so that I can live on my own. But do you know how many millions of fully formed babies like me are warred against? And we die because we are unwanted. But many of us, wanted as we are, still die because parents are ignorant or careless.

Do you know, dad, how terrible I feel when you smoke when mom and me are around? And Oh! Mom, don't you please touch alcohol. It could be the death of me! You could help me, mom, if you eat well. I need all the nourishment you can give me. The best thing you could do is to talk over our needs with health personnel. They will tell you exactly what to do and don't.

Do you know just how I grow? It's like watching a photograph develop from a blurred image, slowly emerging into sharp focus. As I grow, my features sharpen and fine characteristics become evident. The longer I stay inside you mom, the stronger I will be, but I have a chance of surviving even If I'm born in the sixth month of pregnancy.

Did you know that:

—My heart is formed by the 20th day after I was conceived and begins to beat from day 21? From then on it sets the rythmn of life for me?

—Within five weeks my arms, legs and disproportionately large head are formed

—At seven weeks I am about three quarters of an inch long — 40,000 times bigger than the egg from which I came? And that I produce my own blood? My fingers take shape, my toes appear. My nose and mouth and ears take form!

—At eleven weeks I am fully formed and I measure about three inches.

—At 14 weeks my muscles are organised and I will be in constant movement. If you look at me now you will be able to tell whether I am a boy or a girl

—At 18 weeks my nerve tissues mature. I hear noises, I am provoked to react. My brain can record sensations, the effects of which may be felt even long after I am born.

—At 20 weeks I have a legal identity of my own, my very own set of finger prints.

—During the seventh month, I lose my scrawny looks as fat is deposited beneath my skin. My eyes

will be able to open, I will have eyelashes, eyebrows, and hair on my head.

—In the eighth month, I begin to take my position for labour, usually head down.

—During the ninth month, I will be able to flex my arms and legs.

Soon I will open my eyes to the light of the world. But now, I am a very fragile, storm-tossed boat. I am very lovable you know, but also very defenceless. Or so I thought. But I have you both and that is all I need. Your loving, tender care.

Take immense care of me Mom, Dad. For I feel pain and I know hurt. Don't let me be dispensable, there may not be another like me. Help me live. And I'll make it up to you. Some day. I promise.

Lovingly,

YOUR BABY

A baby! Miracle of love! Allowed the right to live, that sperm and egg result in a bundle of joy like this!

Vote for the Girl Child! Let her live

M Leo Raj

If you come down to brass tracks it can be proved beyond doubt that man can be as cruel, as diabolic, as demonic as any of his Animal counterparts. The only difference is that man is a rational, thinking, feeling being — the animal, the opposite. And man has treated woman in the most inhuman way possible. A decade for the woman went by without any real change for the woman at the grass root level. Can we afford another non-decade for the woman?

Let me hasten to clarify that I am the proud, privileged father of two beautiful daughters. I do have a son too, but that was a matter of course — not choice. It is the future of my daughters that has awoken me to the facts of the Girl-Child !

A gynacologist, who subscribes to the theory that abortions are legal and sex-determined abortions a blessing to the girl child wishes to remain anonymous.

"I have seen too much cruelty meted out to the woman. Her life is one long misery — a slow torturous path to ultimate pain and death. Don't you agree it is better to end it all even before she is born?"

"But doctor, you should be life-giver, not life-taker. How can you aid and abet death?"

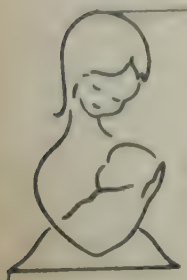
"Don't you think a quick death is better than the long-drawn out one a woman is forced to undergo?!"

The Girl Child! Warred against even before birth. The hue and cry of women in Maharashtra achieved the banning of the aminocentisis test or the 'Sex-determination' tests in the State. But what of the rest of our country? If a roll call is taken, what stand will be ours?

The real discrimination against the female child is not, as everybody thinks, in the poor houses. The fact that poverty does play a great role in the way a girl child is treated is evident — but not justified. Unless the problem of the girl-child is viewed as an integral part of the "poverty-Syndrome" there can be no hope for 'HER' in our poor households.

The real "discrimination" against the female in our society is practiced by the middle classes and the rich. Discrimination, harrassment, and torture, motivated by greed for money. The small family norm is accepted most readily by the well-to-do, and they are able to achieve the "one-boy, one-girl" or "one boy" limit by the selective abortion of the female child, oops! sorry, female *fetus*, not *child!*

It must be stressed here that it is only the rich and the middle class who can afford the sex-determination tests that guide the parents to allow the child to live or die!



The girl child who manages to be born faces all the problems of being unwanted. Always on the lowest rung of any household ladder, the girl-child takes her second-class status as a matter of course.

What helps perpetuate this fallacy is the fact that even the media sees her as such and works on that basis. An example that comes to mind is an ad on the national TV network at prime time. A young mother of a girl child being served by her mother-in-law dry rotis and a measely mess of vegetable because she was unfortunate enough to give birth to a girl. The ad proceeds to explain that this young mother needs all the food and nutrition she can get because she needs to nurse her child, girl-child or not. And like all heartwarming, fairytale endings, the husband, in an act of condescension and bravado, feeds his wife a morsel of food that is reserved for him and the males of the family!

When will we begin to realise that a woman needs nutrition and good food and good health care, not because she is expecting a baby or because she is nursing a baby but simply because she is a human being and that itself gives her a right to the "good" life! If a woman is not expecting, is not nursing, she can live comfortably on dry rotis! Is this what we are saying? Obviously the media does need some deeper-thinking, right-thinking folk on their ad-making panels! Because this is only one of their many goof-offs, especially concerning women!

All the women and all the girl-children who watch this are told in no uncertain manner that they have a "right" to eat only because they need to nurse their childern! What kind of education, this ?

Subhadra, teacher; 37 says: "Thank God I have only two sons. My in-laws hate girls. They feel girls are a burden, to be fed, clothed, sent away, that too with heavy dowries."

"What of you, yourself Subhadra?"

"Me, I'm just thankful I have no daughter, who would have had to suffer as I am doing!"

If teachers too feel this way, who will educate the woman to change her lot?

If born, what exactly is the lot of a girl child?

If born, the unfortunate girl child is born into bondage - she is some man's daughter some man's sister, some man's wife, some man's mother, some man's widow! By herself nothing, noone!

At birth, instead of being welcomed with jubilation, she usually is bathed in the tears of her mother — or drowned by her curses.

In infancy she finds that either her mother has insufficient milk to aid her growth — or no inclination to worry about this unimportant detail.

Her mother also finds neither the time nor the inclination to keep her immunization schedule, she's a girl after all — belong to another household — what need to spend my precious time and energy on her?

In childhood, good food, nutrition, health — care facilities, education — all these are for her brother, not for her. Society does acknowledge that the woman is mother, nurturer, caretaker of the children, educator! Yet she must be all these without the benefit of either good food or education!

In girlhood, taught to accept the role of household drudge, the girl-woman takes on the doestic tasks and the yoke of marriage as a matter of course.

Listen to what Marcella Thomas; 14 year old 9th Class student has to say: "At home I wash plates,

clear the table, help wash, clean, scrub. My brother watches TV or plays the guitar! I'm told I have to learn to cook and be a good housewife. I'm also learning typing and shorthand. I'll become a Secretary. But I'll still have to do housework".

"What are you doing about that Marcella?"

"What can I do? My mother says — and I obey!"

The girl also takes on abusive in-laws and husbands whose superiority is forced down her throat in a myrid ways — even to the extent of physical torture and death at their hands.

Kisthiah, construction worker, 59 said: "I threw my first wife out of the house because she gave me two daughters. No son. Now I've got another woman. She bore two sons. They work with me. They earn money. They will fetch dowry. Their wives will work on the construction site and in the house."

"Will your sons too throw out their wives, Kistiah, if they have daughters?"

"If they call themselves men, they too will stand no nonsense!"

Pushpita: Professor in English; 40, feels differently:

"Daughters are gems. Unfortunately I have only one. My sons have grown, will become independent men in their own right. My daughter, according to society will be a dependent. I will not allow that. I will see to it that she gets a good education and is financially, physically and mentally independent not needing to kwotwo to any man!"

"What happens Pushpita, if she marries a man who demands servitude and dependence?"

"My daughter, the way I'm bringing her up, will be quipped to deal with every contingency!"

As mother, her fate plays cruel jokes on her. In poverty stricken households she has to choose who to feed — the strong young boy or the weak ill child —

or the girl-child who at best is only a burden! At another level, on a different topic, she has no choice. If the family can afford a sex determination test and her husband and family decides that the girl child must go, this mother has not a sliver of a chance to protest! She becomes a murderer — and usally not by choice.

As a widow, the most stringent rules apply. She wear only white, are not allowed most foods, not permitted to participate in any celebrations, faced with society's recriminations, often held responsible for the husband's death! She lives in the shadows and patiently awaits the left-overs of food, the cast off clothes and often absolutely no love or affection from the family! Any wonder then, that in the olden days women preferred the quick way to end it all by Sati!!

And as an old woman, frustrated and bitter at the treatment she endured, she becomes a fanatic in the protection of the girl-child. She teaches the girl to be silent, suffer in patience, obey her lord and master and make do with whatever crumbs of mercy, love or food that come her way.

Ramesh Reddy, an engineering graduate, 25, has a new way of seeing things: "I think its stupid the way people go on about a better life style for women. You should have seen the girls in our College! They were in no way inferior to us!"

"Are you sure Ramesh, that this is universal?"

"Sorry, in the urban well-to-dos, this is true. It is the millions of others who suffer. I wish though that educated, aware women would stop fighting to be equal. They are equal. They just need to behave so and will be accepted. My daughters, and I hope to have atleast two, will grow up that way."

Today, women are more aware that they have a right to a better fate. But the tragedy is that she continues to allow whatever is done to her — I'm sure, but not by choice.

Today she is not only wife, mother, nurturer, housekeeper and educator,but also a wage-earner. In most middle class homes the 'wage-earner' status has brought on added misery!

The ego of the man is hurt! He has to send his wife to work. She'll soon want to be treated well if not equal! She'll begin to lose respect for the 'Lord' so the offensive comes into play. Home and children should be doubly cared for, the lord and master shown extra servility or else the woman is ticked off for being career-oriented, for neglecting the household, for 'acting too smart' because she happens to bring a few rupees into the family kitty!!

The irony of it all is when this "small time" wage earner is kicked and abused and relieved of her earning so that her lord can go spend it on wine, women or song!

Thank God I was not born a woman! Man has his problems but man-made, hence acceptable. Woman has oppression, also man-made! Will man awaken to the mistakes he has made? Will the woman awaken to the fact that she too was once a girl-child? Will the year for the girl-child help? Or are we doomed to decades of rhetoric and nothing more?

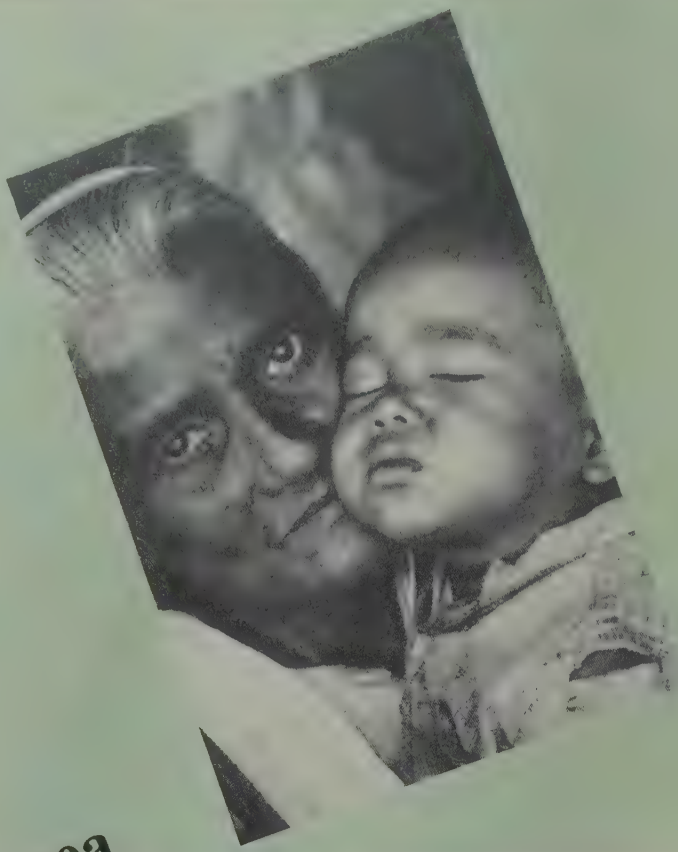
I spoke to Butchi, 10 year old slum dweller: The child on her hip is heavy, keeps slipping down but Butchi bears this burden with love and a smile on her face. Confronted by my insensitive questions, she's wistful.

"I wish I could go to school. I want to become a teacheramma. But there's no one to look after my brothers and sisters. Both my parents go to work. I cook and take care of the house and children."

"Do you have time to play, Butchi?"

The large expressive eyes are answer enough. One fathoms that the Butchies of this world play only in their dreams.

Child Health



Diarrhoea

1. Diarrhoea can kill children by draining too much liquid from the body. So it is essential to give a child with diarrhoea plenty of liquids to drink.
2. When a breastfed child has diarrhoea, it is important to continue breastfeeding.
3. A child with diarrhoea needs food.
4. Trained help is needed if diarrhoea is more serious than usual.
5. A child who is recovering from diarrhoea needs an extra meal every day for at least a week.
6. Medicines should not be used for diarrhoea, except on medical advice.
7. Diarrhoea can be prevented by breastfeeding, by immunizing all children against measles, by using latrines, by keeping food and water clean, and by washing hands before touching

Diarrhoea

1

Diarrhoea can kill children by draining too much liquid from the body. So it is essential to give a child with diarrhoea plenty of liquids to drink.

◯ Diarrhoea is dangerous. Roughly one in every two hundred children who get diarrhoea will die from it.

◯ Most often, diarrhoea kills by dehydration, which means that too much liquid has been drained out of the child's body. So as soon as diarrhoea starts, it is essential to give the child extra drinks to replace the liquid being lost.

◯ Suitable drinks to prevent a child from losing too much liquid during diarrhoea are:

○ Breastmilk

○ Gruels (diluted mixtures of cooked cereals and water)

○ Soups

○ Rice water

◯ In almost all countires, special drinks for children with diarrhoea are available in pharmacies, shops, or health centres. Usually, these come in the form of packets of oral rehydration salts (ORS) to be mixed with the recommended amount of clean water (see box). Although these 'salts' are specially made for the treatment of dehydration, they can also be used to prevent dehydration.

Do not add ORS to liquids such as milk, soup, fruit juice or soft drinks.

◯ An effective drink for diarrhoea can also be made by using eight level teaspoons of sugar and one of salt dissolved in one litre of clean water.

◯ If none of these drinks is available, other alternatives are:

○ Fresh fruit juice

○ Weak tea

○ Green coconut water

◯ If nothing else is available, give water from the cleanest possible source (if possible brought to the boil and then cooled).

◯ To prevent too much liquid being lost from the child's body, one of these drinks should be given to the child every time a watery stool is passed:

○ Between a quarter and a half of a large cup for a child under the age of two

○ Between a half and a whole large cup for older children

◯ The drink should be given from a cup (feeding bottles are difficult to clean properly). If the child vomits, wait for ten minutes and then begin again, giving the drink to the child slowly, small sips at a time.

◯ Extra liquids should be given until the diarrhoea has stopped. This will usually take between three and five days.

Reprinted from UNICEF's 'Facts for Life'

ORS — a special drink

A special drink for diarrhoea can be made by using a packet of oral rehydration salts (ORS). This drink is used by doctors and health workers to treat dehydrated children. But it can also be used in the home to prevent dehydration. To make the drink:

○ Dissolve the contents of the packet in the amount of water indicated on the packet. If you use too little water, the drink could make the diarrhoea worse. If you use too much water, the drink will be less effective.

○ Stir well, and give to the child to drink in a cup.

2

When a breastfed child has diarrhoea, it is important to continue breastfeeding.

◯ When a breastfed child has diarrhoea, breastfeeding should continue, and if possible increase. If the child cannot suck, it is best to squeeze out the breastmilk and feed it to the child with a clean cup.

◯ If the child is being fed on milk powder solutions or cow's milk, more liquid should be given by adding twice the usual amount of clean water to the child's normal feed.

3

A child with diarrhoea needs food.

◯ It is often said that a child with diarrhoea should not be given any food or drink while the diarrhoea lasts. This advice is wrong. Food can help to stop the diarrhoea. Also, diarrhoea can lead to serious malnutrition unless parents make a special effort to keep feeding the child during and after the illness.

◯ A child with diarrhoea usually has less appetite, so feeding may be difficult at first. But the child should be tempted to eat frequently, by offering small amounts of his or her favourite foods.

◯ Children who eat solids should be given soft, well–mashed mixes of cereal and beans, or cereal and well–cooked meat or fish. Add one or two teaspoonfuls of oil to cereal and vegetable mixes if possible. Also good for the child are yoghurt and fruits (especially brightly coloured fruits such as bananas, mangoes and pineapples). Foods should be freshly prepared and given to the child five or six times a day.

4

Trained help is needed if diarrhoea is more serious than usual.

◯ Parents should seek help from a health worker without delay if the child:

○ Becomes dehydrated. Some signs of dehydration are:

Sunken eyes
Extreme thirst
No tears when the child cries

○ Has a fever

○ Will not eat or drink normally and vomits frequently

○ Passes several watery stools in one or two hours.

○ Passes blood in the stool (a sign of dysentery)

◯ If a child has any of these signs, qualified medical help is needed quickly. The doctor or health worker will give the child a drink made with special oral rehydration salts (see box). In the meantime, keep trying to make the child drink liquids.

Reprinted from UNICEF's 'Facts for Life'

5

A child who is recovering from diarrhoea needs an extra meal every day for at least a week.

◯ Extra feeding after the diarrhoea stops is vital for a full recovery. At this time, the child has more appetite and can eat an extra meal a day for at least a week. This will help the child to catch up on the food 'lost' while the child was ill and the appetite was low. A child is not fully recovered from diarrhoea until he or she is at least the same weight as when the illness began.

◯ Breastfeeding more frequently than usual also helps to speed up recovery.

6

Medicines should not be used for diarrhoea, except on medical advice.

◯ Most medicines for diarrhoea are either useless or harmful. The diarrhoea will usually cure itself in a few days. The real danger is usually not the diarrhoea but the loss of liquids from the child's body.

◯ Do not give a child tablets or other medicines for diarrhoea unless these have been prescribed by a trained health worker.

7

Diarrhoea can be prevented by breastfeeding, by immunizing all children against measles, by using latrines, by keeping food and water clean, and by washing hands before touching food.

◯ Diarrhoea is caused by germs from faeces entering the mouth. These germs can be spread in water, in food, on hands, on eating and drinking utensils, by flies, and by dirt under fingernails. To prevent diarrhoea, the germs must be stopped from entering the child's mouth.

◯ Poverty and lack of basic services such as clean drinking water mean that many families find it difficult to prevent diarrhoea. But the most effective ways are:

○ Give breastmilk alone for the first four–to–six months of a baby's life (breastmilk helps to protect babies against diarrhoea and other illnesses).

○ At the age of four–to–six months, introduce clean, nutritious, well–mashed, semi–solid foods and continue to breastfeed.

○ If milk–powder solution or cow's milk has to be used, give it to the child from a cup rather than a bottle.

○ Use the cleanest water available for drinking (water from wells, springs or rivers should be brought to the boil and cooled before use).

○ Always use latrines to dispose of faeces, and be sure to put children's faeces in latrine, or bury them, immediately (children's faeces are even more dangerous than those of adults).

○ Wash hands with soap and water immediately after using the latrine and before preparing or eating food.

○ Cover food and drinking water to protect it from germs.

○ If possible, food should be thoroughly cooked, and prepared just before eating. It should not be left standing, or it will collect germs.

○ Bury or burn all refuse to stop flies spreading disease.

◯ Measles frequently results in serious diarrhoea. Immunization against measles therefore also protects a child against this cause of diarrhoea. There is no vaccine to prevent ordinary diarrhoea.

Reprinted from UNICEF's 'Facts for Life'

Coughs and Colds

1 If a child with a cough is breating much more rapidly than normal, then the child is at risk. It is essential to get the child to a clinic quickly.

2 Families can help prevent pneumonia by making sure that babies are breastfed for at least the first six months of life and that all children are well–nourished and fully immunized.

3 A child with a cough or cold should be helped to eat and to drink plenty of liquids.

3 A child with a cough or cold should be helped to eat and to drink plenty of liquids.

4 A child with a cough or cold should be kept warm but not hot, and should breathe clean, non–smoky

Coughs and Colds

1

If a child with a cough is breathing much more rapidly than normal, then the child is at risk. It is essential to get the child to a clinic quickly.

○ Most coughs and colds, sore throats and runny noses will get better by themselves. But sometimes pnenumonia develops and threatens the child's life. Millions of child deaths from pneumonia could be avoided if:

○ Parents know when a cough or cold is becoming a serious infection which needs medical attention.

○ Medical help and low-cost drugs are available.

○ Parents of child with a cough should know that it is essential to get the child to a clinic or a trained health worker quickly if:

○ The child is breathing much more rapidly than normal (over 50 times a minute).

○ The lower part of the child's chest (the area between the two halves of the child's rib cage) goes in as the child breathes in instead of expanding outwards as normal.

○ The child is unable to drink anything.

○ If a child is breathing normally, coughs and colds and runny noses can be treated at home without drugs. Most medicines sold for coughs and colds are useless or harmful.

2

Families can help prevent pneumonia by making sure that babies are breastfed for at least the first six months of life and that all children are well-nourished and fully immunized.

○ **Breastfeeding**

Breastmilk helps to protect against infections. On average, babies who are bottlefed have twice as many

Reprinted from UNICEF's 'Facts for Life'

bouts of pnenumonia as babies who are breastfed. It is particularly important to give breastmilk alone for the first four–to–six months of a baby's life.

○ **Feeding**
At any age, a child who is well–fed is less likely to become seriously ill or to die because of pnenumonia.

○ **Vitamin A**
Vitamin A, from orange or yellow fruits and dark green leafy vegetables, also helps to protect against pnenumonia.

○ **Immunization**
Immunization should be completed before the child is one year old. The child will then be protected against some of the most common causes of serious respiratory infections, including whooping cough, tuberculosis and measles.

○ **Crowding**
Overcrowding helps the spread of coughs and colds. At night, infants who are breastfed can sleep with the mother. But older children should be encouraged to sleep on their own.

3

A child with a cough or cold should be helped to eat and to drink plenty of liquids.

○ The important things to remember when treating a child at home are:

○ **Continue feeding**
A breastfed child with a cough or cold may be difficult to feed. But feeding helps both to fight the infection and to protect the child's growth. So it is important to persist in frequent attempts to give breastmilk. Often, clearing the child's blocked nose will help the child to suck If a child cannot suck, it is best to squeeze out the breastmilk and feed the child from a clean cup.

Children who are not being breastfed should be coaxed into eating frequent small amounts. Periods of 'starvation' caused by illness and lost appetite are a major reason for poor growth. When the illness is over, a child should be fed an extra meal each day for a week. Recovery is not complete until the child is at least the same weight as when the illness began.

○ **Give plenty of fluids**
All children with coughs and colds need to drink plenty of liquids.

4

A child with a cough or cold should be kept warm but not hot, and should breathe clean, non–smoky air.

○ **Keep warm not hot**
Babies and very young children lose their heat easily, so it is important to keep them covered and warm, but not too hot or too tightly wrapped.

Fever is not always a sign of severe illness. But if a child has a fever, paracetamol (or other temperature–reducing medicine) can be given.

○ **Help in breathing**
A child's nose should be frequently cleared, especially before breastfeeding or when being put to sleep. Young babies should be allowed to sleep lying on the stomach. A moist atmosphere can help to ease breathing. It can also help if the child inhales water vapour from a bowl of hot but not boiling water.

The air in the child's room should be kept fresh by opening a door or window two or three times a day, but a child with a cough or cold should be kept away from draughts.

○ **Clean air**
Children who live and sleep in smoky surroundings, either because of cooking fires or tobacco smoking, are more likely to get pneumonia.

Spitting and sneezing by other people close to children also increases the risk. people with coughs and colds should be kept away from young babies.

Reprinted from UNICEF's 'Facts for Life'

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad–500 003. Ph: 841610

Hygiene

1 Illness can be prevented by washing hands with soap and water after contact with faeces and before handling food.

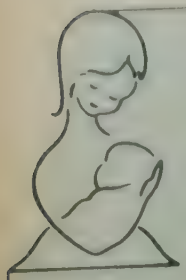
2 Illness can be prevented by using latrines.

3 Illnesses can be prevented by using clean water.

4 Illnesses can be prevented by boiling drinking water if it is not from a safe piped supply.

5 Illnesses can be prevented by keeping food clean.

6 Illnesses can be prevented by burning or burying household refuse.



Hygiene

1

Illnesses can be prevented by washing hands with soap and water after contact with faeces and before handling food.

◯ Washing hands with soap and water removes germs from the hands. This helps to stop germs from getting onto food or into the mouth. Soap and water should be easily available for all members of the family to wash their hands.

◯ It is especially important to wash hands after defecating, before handling food, and after cleaning the bottom of a baby or child who has just defecated.

◯ Children often put their hands into their mouths. So it is important to wash a child's hands often, especially before giving food.

◯ A child's face should be washed at least once every day. This helps to keep flies away from the face and prevent eye infections. Soap is helpful for washing, but not absolutely essential.

2

Illnesses can be prevented by using latrines.

◯ The single most important action which families can take to prevent the spread of germs is to dispose of faeces safely. many illnesses, especially diarrhoea, come from the germs found in human faeces. People can swallow these germs if the germs get into water, onto food, onto the hands, or onto utensils and surfaces used for preparing food.

◯ To prevent this happening:

○ Use latrines.

○ If it is not possible to use a latrine, adults and children should defecate well away from houses, paths, water supplies, and anywhere that children play. After defecating, the faeces should be buried. Contrary to common belief, the faeces of babies and young children are even more dangerous that those of adults. So even small children should be taken to use the latrine. If children defecate without using a latrine, then their faeces should be cleared up immediately and either put down the latrine or buried.

○ Latrines should be cleaned regularly and kept covered.

○ Keep the faeces of animals away from homes and water sources.

3

Illnesses can be prevented by using clean water.

◯ Families who have a plentiful supply of safe piped water, and know how to use it, have fewer illnesses.

Reprinted from UNICEF's 'Facts for Life'

◯ Families without a safe piped water supply can reduce illnesses if they protect their water supply from germs by:

○ Keeping wells covered

Keeping faeces and waste water (especially from latrines) well away from any water used for cooking, drinking, bathing or washing

○ Keeping buckets, ropes and jars used to collect and store water as clean as possible (for example by hanging up buckets rather than putting them on the ground)

○ Keeping animals away from drinking water

◯ Families can keep water clean in the home by:

○ Storing drinking water in a clean, covered container

○ Taking water out of the container with a clean ladle or cup

○ Not allowing anyone to put their hands into the container or to drink directly from it

○ Keeping animals out of the house

4

Illnesses can be prevented by boiling drinking water if it is not from a safe piped supply.

◯ Even if water is clear, it may not be free from germs. The safest drinking water is from a piped supply. Water from other sources is more likely to contain germs.

◯ Boiling water kills germs. So, if possible, water drawn from sources such as ponds, streams springs, wells tanks or public standpipes should be brought to the boil and cooled before drinking. It is especially important to boil and cool the water which is given to babies and young children, because they have less resistance to germs than adults.

◯ If boiling is not possible, store drinking water in a closed or covered container of clear plastic or glass, and leave it standing in sunlight for two days before using it.

5

Illnesses can be prevented by keeping food clean.

◯ Germs on food can enter the body and cause illness. But food can be kept safe by:

○ Making sure that food is thoroughly cooked, especially meat and poultry.

○ Eating food soon after it has been cooked, so that it does not have time to go bad.

○ It food has to be kept for more than five hours, it should either be kept heated or kept cooled.

○ If already-cooked food is saved, it should be thoroughly re-heated before being used again.

○ Raw meat, especially poultry, usually contains germs. So it should not be allowed to come into contact with cooked meat. Utensils and food-preparing surfaces should be cleaned after preparing raw meats.

○ Keeping food-preparing surfaces clean.

○ Keeping food clean and covered and away from flies, rats, mice and other animals.

6

Illnesses can be prevented by burning or burying household refuse.

◯ Germs can be spread by flies, which like to breed in refuse such as food scraps and peelings from fruit and vegetables. Every family should have a special pit where household refuse is buried or burned every day.

Reprinted from UNICEF's 'Facts for Life'

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

Trikaya Grey AE.1.89

When the phone rings, do you reach for the receiver or the air conditioner switch?

If you switch off the air conditioner every time you take a call because you can't hear a word. If you find yourself raising your voice at meetings when there's no cause to. If you've had enough of noisy air conditioners, get yourself an Amtrex split. It has a separate condenser unit that's placed outside, so it makes no noise. And a perfectly streamlined air-delivery system inside. Which makes it the most noiseless split air conditioner available. It can be installed on the ceiling. But it's also available as a floor and wall model. It comes in a choice of 1, 1.5 and 2 tons. As well as multi-split models of 2, 3 and 4 tons that cool more than one room simultaneously. (The widest range in the market today). It's already been installed at some of the largest companies in India: Reliance Industries, Food Specialities Limited and Crompton Greaves, amongst others. To get one, raise your voice for one last time and call Amtrex.

AMTREX

SPLIT AIR CONDITIONERS

Amtrex Ambience Pvt. Ltd. (An Enterprise of Lalbhai Industries Consolidated.) Corporate Office: 'Rachana', Shahibaug Road, Ahmedabad - 380004 Offices Ahmedabad 383035 Ambala - Bangalore 563291 Baroda 323677 Bhopal 62109 Bhubaneshwar 52034 Bombay 2040447 Calcutta 441092 Chandigarh 25147 Gauhati 32683 Goa 22346 Indore 65140 Jaipur 68797 Lucknow 40670 Madras 451301 New Delhi 6835986 Pune 661693 Raipur 23093 (P P) Secunderabad 226755 Vizag 66160

An under-nourished young India

Chanda Agashe

Under nutrition continues to pose a public health problem in many developing countries.

In India although in the last three decades remarkable progress was made in agricultural production, the nutritional problem has not been solved. This is due to tremendous concurrent growth of population. Even if average per capita availability of food is raised to the required level the problem will not be solved unless equitable distribution among different segments of the population is ensured. Above 40% of our population lives below "the poverty line" and cannot afford even the least expensive balanced diet. A majority of them suffer from "under nutrition" and a significant proportion show frank deficiency signs.

Children of preschool age are the most important and most vulnerable. Nearly 40% of all deaths which occur in the country are among children below five years of age, and the background of wide spread malnutrition contribute significantly to this high toddler mortality. Among survivors, morbidity is also of a great concern. There is now increasing evidence that malnutrition during early childhood can lead to stunting of physical growth, culminating in small adult size, but also to the impairment of vital functions in later life. These include resistance to

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad- 500 003. Ph: 841610

infection, physical stamina, work capacity, as well as learning ability. A compromise in these functions can lead to ill-health and reduced productivity.

The important deficiency diseases of public health magnitude are —

Protein Energy Malnutrition or PEM:

PEM is the most widespread nutritional disorder among children. Kwashiorhar and Marasmus are the two well-recognised clinical syndrome of severe PEM. However a country wide nutrition survey carried out on a large number of preschool children showed that the majority of them had heights and weights below American children.

Although it is suggested that there may be racial difference in the genetic potential for growth, the recent studies have shown that growth pattern of Indian children belonging to well-to-do communities is similar to that of children in affluent parts of the world. Hence growth retardation is due to environmental factors out of which nutrition is an important one.

Nutritional Blindness:

Xerophthalmia includes all signs, that develop as a result of vitamin A deficiency. It is the most important cause of blindness in children. Breast fed infants grow well, and do not develop any deficiency signs. It is however possible that they are drawing on reserves. This possibllity is supported by the observations that children of such communities do develop deficiency signs later on during early childhood.

Nutritional Anaemia:

Although milder form of anaemia does not produce any dramatic effects, recent studies have shown that work efficiency and resistance to infection is lowered due to low Haemoglobin levels. Iron value in Indian foetesus are low due to low foetal weight and lower iron stores in the foetus due to maternal iron deficiency. This phenomenon may be aggravated in later life due to either excessive iron loss or very poor bio-availability of dietary iron or both.

Endemic Goitre:

Goitre is seen extensively along the sub-Himalayan belt and in certain parts of central India. It has been shown that endemic goitre is due to Iodine deficiency.

These are some of the major public health problems.

Malnutrition not the only cause

However malnutrition is not only a problem of food supply but can also be a result of more complex bio-social and behavioural determinants affecting child bearing and child rearing. A study carried out in the above mentioned context indicated that:—

a) Infants had better nutritional status than toddlers. This could be because infants are able to satisfy their nutritional needs through breast milk and some complementary food. However after the first year of life when breast feeding no longer meets their nutrient needs and complementary food is inadequate, prevalence of under nutrition increases.

b) Maternal height and weight were found to have significant association with the nutritional status of the infant. This could be attributed to the fact, that maternal nutritional status is determined from lactation performance and therefore inevitable to the status of infant nutrition.

c) Higher caste children had better nutritional status.

d) Toddlers from large families had better nutritional status than those from medium sized or small families. This could be due to the likelihood of adult women being able to care for young children.

e) Poor housing and poor sanitary conditions were found to adversly affect the nutritional status of children (below four years). It may be due to greater frequency of infectious diseases.

f) Improved levels of maternal nutrition have been associated with reduced child mortality and malnutrition.

g) Mothers of malnourished group of children were all working outside the home. This is due to reduced time for child care, although increased income made food available to the household.

h) Increase in maternal weight was corresponding to increase in the proportion of well nourished toddlers.

i) Female children had worse nutritional status than male children. This may be because males are seen as important source of labour on the family farm.

j) They are expected to provide economic and social security for their parents when they are old, or incapaciated or in times of distress and the family name is carried by sons.

The above study is supported by another study which was done on growth and development of children between zero to 10 years. The study indicated that the majority of children had varied degree of malnutrition. The annual incidence of diarrrohea and upper tract infection was high in infants between seven to 12 months, and showed a decrease with increasing age and improved nutritional status. However the majority of children show normal motor development, normal adaptive and personal-social behaviour.

Hence malnutrition and other nutritional deficiencies in preschool children from low socio-economic groups is manifestation of many causes — economical and sociological factors.

Supporting the above conclusion a study conducted on rural preschool children and urban preschool children of different economic status showed that poor growth of rural preschoolers of low socio-economic group is due to diet low in fat content, although bulk or volume of food consumed daily is similar to that of urban children. Diet low in fat contributed to low energy density as fats are concentrated sources of energy. Low energy intake had adversly affected the growth.

Preschool children form a vulnerable group. Hence extensive studies have been done.

School going children:

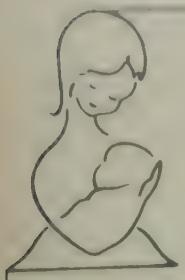
However health and nutritional status of school going children is equally important. These children (five to 14 years) are less vulnerable from the nutrition standpoint. There is lower mortality among them than their younger counterparts.

Study done on rural school boys indicates that major problems during this age group were of vitamin deficiencies, anaemia, dental caries, and common infections of skin, scalp throat, ear and eyes. Angular stomatis, xerosis, Bitot's spots and Phrynoderma are main deficiency sings. They were lighter and shorter than well-to-do Indian Children. Also delay in adolescent grouth spurt is often attributed to poor nutrition and primitive environmental conditions.

This condition can be improved to some extent by well planned and judiciously followed school lunch programme or Midday Meal Programme (MDM).

Some doubts have been raised about the effectiveness of such feeding programmes, but a well planned school lunch programme has certain gains. This opinion has been expressd by two Indian studies.

The school lunch programme has the following gains. It has ability to satisfy the hunger of children who come to school with an empty stomach or after a little breakfast.



Supplementary food had a positive impact on their nutritional status. The gain was manifested first in body weight and later in height increments. Hence through such programmes, much needed dietary supplements can be delivered.

The most important gain at MDM would be that this nutrition can make up for the deprivation, neglect and nutritional impoverishment of the earlier years of life. Preschool child interventions are thus useful in bringing children through the most critical period, the MDM programme sustains and develops their nutritional and health status at school age.

As our interest is not only in the number of surviving children but in a healthier child population the MDM programme has an important role in strategies concerned with malnutrition, ill health and poor intellectual performance.

Nutritional Status of Working Children:

In 1959, the General Assembly of the United Nations issued the Declaration of the Rights of the Child. It states that the child shall not be admitted to employment before an appropriate minimum age. He shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.

It has been suggested that work for wages may have greater effect on the exploitation and unregulated often hazardous nature of the working conditions.

A Study conducted in Andhra Pradesh which has particularly high child labour participation rate, has estimated that in Andhra Pradesh 16% of children between five and 14 years of age form part of the labour force.

Although the United Nations has issued a Declaration, all features of the Declaration are not accounted and working children do exist.

The growth and development of working children were compared with students who were matched for nutritional status at the age of five years.

The severely under-nourished group grew up as shortest and lightest young adults. Hence it emphasizes the importance of nutrition during early periods of life.

In comparison to students, working children lost considerable ground and suffered significant growth deficits as adults.

This difference reflects a difference in socio-economic level, since sending out a child to paid work is a symptom of the social distress of poor families. The working children are thus exposed to a range of handicaps, inadequate food intake, excessive energy expenditure, frequent illnesses, insufficient primary health care and a less favourable psycho-social atmosphere.

★ Give me the child until he is seven and I shall give you the man

★ Give continuous consistant love

This is the most important need, because it provides a basis for all relationships later in life.

This love is perhaps best expressed in the early months by direct bodily contact, and also by satisfying the baby's need for food.

★ Give generously of time and understanding

Young children need adults or older siblings who will spend time with them.

Right food for children

A Health Action report

What makes a bonny baby? Of course a lot of motherly smothering, kisses and hugs and tons and tons of love. But will that suffice? Have you stopped and wondered in between the number of daily feeds your baby needs, whether your baby is getting the right kind of food for a better growth? If you have, read on to find out what makes a better baby. You will also get to know what older babies-children upto 14 require for better growth.

Nutrition in Infancy (0 to six months,six months to one year):

Infancy is one of the most crucial periods in the life cycle as far as food is concerned. Nutrient needs in relationship to size are high and optimal nutrition at this time is very important to health and vigour throughout life. This period is marked by rapid growth.

Infants need food for energy and repair of wear and tear of tissues. Extra nourishment is essential for the continuous increase in size of every part of the child's body. Additional calories are needed for increased activity as the child grows. The actively growing tissues and the high energy output demands protective nutrients to regulate various functions of the body and keep the young ones in perfect health.

BREAST FEEDING

Breast feeding is nature's way to feed the baby. It has certain advantages. Firstly breast feeding permits early establishment of an intimacy with the child that bodes well for the mother-child relationship. Besides this human milk from a well nourished mother, when consumed in amounts sufficient to fulfil calorie needs, will meet the recommended intake of all nutrients for the infant at least for the first three months of life. Breast milk has bactericidal effect and also inhibits growth of certain pathogens. Human milk also contains antibodies important in immunizing the infant against certain infectious diseases. Human milk is also less likely to cause allergic reactions.

Breast milk is safer than a poor formula milk, or one unhygienically prepared. It is free from contamination and requires no preparation.

Studies have indicated that breast milk is satisfactory to the majority of infants upto three months of age.

Contra indications to Breast Feeding: These are very few and are as follows — Acute illness in mother, chronic illnesses such as T.B., kidney disease, diabetes, etc. Severely and permanently inverted nipples, diseased breast or nipples.

When breast milk is not available infants can be artifically fed either on cow's milk or formula milk. Cow's milk, can be diluted with boiled water initally. Sugar has to be added.

Formula milk can be made as per specific directions issued by manufacturers. Excessive dilution would reduce the infants nutritive intake, while concentrated form would result in vomiting. Care should be taken to sterilize bottles, nipples, and whatever is used in preparing milk.

Weaning:

Weaning period is a crucial time in the child's life when he shifts gradually from exclusive breast feeding to the adult diet.

The available evidence suggests that four to six months is perhaps the most appropriate age for introducing supplementary foods.

Since breast milk is sufficient in most cases upto the third month, supplements may be started later. Early deprivation of breast milk, and substitutes which are inadequate in nutrition may lead to marasmus at a relatively early age.

Also if supplementation is delayed, and inadequate weaning foods are introduced to infants, nutritional problems may arise after one year of age. In many cases signs of malnutrition may show by seventh or eighth month.

Care should be taken for proper hygiene in introducing weaning foods or formula milk. There are several reports to show that the incidence of weaning diarrhoea is high during the weaning period. It is an important cause of not only infant mortality but also malnutrition in surviving children.

Weaning must be gradual. It can commence by omitting one nursing feed and in its place feeding a suitable quantity of supplementary food. Gradually the baby is given more frequently small quantities of different supplementary foods and the frequency of breast feeding is reduced to the minimum.

The supplements are classified on the basis of the physical quality.

Liquid Supplements: They are first introduced to the infant. Animal milk, fresh fruit juices diluted with water. Strained or clean vegetable soups. Fish liver oil can be used.

Solid Supplements (sieved or mashed). They include cooked mashed cerealvegetables, boiled egg yolk followed by boiled egg white, finely ground minced meat, boiled mashed fish, finely cooked and mashed dals, mashed bananas, or stewed fruit pulp.

Solid Supplements (chopped or lumpy): When baby starts cutting teeth, chopped or lumpy foods, can be given well boiled and soft leafy vegetables, bits of cooked potatoes, soft cooked rice, a piece of chapati a piece of toast or hard biscuit can be given. Care should be taken to see baby does not choke. A slice of raw carrot or fruit segments with skin and seed removed can be given.

NUTRITION FOR PRESCHOOLERS (one to five years)

Nutritional Requirements of early childhood: The calorie requirement from one to three years are relatively low and hence in order to ensure a diet adequate in other nutrients, careful selection of the toddler's food is essential.

Protein needs for growth of muscles and other tissues are relatively high during this period. If the child consumes enough milk, egg, or meat these needs can be met.

Feeding the toddler: The one year old begins to show a decided change in appetite and interest in food. There may be a marked decrease in milk intake. Also other foods are not eaten eagerly as it was earlier and some foods may be refused altogether. This should not be interpreted as a "poor" appetite but rather normal appetite for that age.

All this is due to decrease in growth rate and the child's interest in his surroundings. The child would want to play with his food, to feel its texture and he tries to feed himself with his hands. It is important to understand that changes in food acceptance, and the need for exploration are a part of the normal growth pattern.

As the child grows, the texture of food offered changes. Bright coloured foods, like pieces of carrot, tomato can be offered. Also "Finger foods" can be introduced. It means serving food in such a way that the child can pick up, by fingers and eat by himself. Meat served should be tender and cut into small pieces. Vegetables, bread, fruit, chapati can be served in small pieces. As the child grows, more solid foods and finally food from the family table can be introduced.

FEEDING THE PRESCHOOLERS — (four to six years)

Preschoolers are relatively independent at the table as far as feeding themselves. Hence sturdy child size tables and chairs can be used. Food can be served in non-breakable dishes and liquids in such glasses, with these, the child can manage his food on his own.

Meal Suggestions: Children like regularity, so eating at the same time is preferable and helps to control appetite. Regula meals can also help to avoid fatigue which can interfere with emotion as well as appetite. The family can have meals together as in company the child is likely to eat more. Small amounts of food can be offered, several times a day. If the child is tired, he many not eat well, hence a short rest period is advisable.

Parental eating habits and their attitudes are the most influential factors on the child's food preferences. Foods that are disliked by one or both the parents will be served less frequently or not served at all. Hence the child may not develop a taste.

Food jags are common among this age group. It means refusal to eat anything, except one food at each meal. This may be a way for the child to assert

his new independence. This is typically a developmental state.

The child should not be forced to eat specially when he is not hungry. Also the child should have an option of refusing certain foods as well as having additional serving of food which he likes.

This is a critical period during which lifelong food habits are forming. Good habits established at this time will affect to some extent the individual's health throughout life. So it is important to include a variety of foods during this time.

NUTRITION FOR CHILDREN AND YOUTH

There is a gradual increase in growth and therefore nutrient requirement increase with age. Adolescent growth spurt is markedly different for boys and girls, hence the nutrient requirements also vary.

It is important that adequate calories are provided for normal growth. When calorie intake is below the requirement, protein foods will be used for energy instead of "tissue building" Protein, needs to be increased with growth and the same is the case of other nutrients.

FOOD HABITS OF SCHOOL AGE CHILD (5 to 10 years)

Children's food habits develop along with other aspects of their growth. As the child grows, he takes a variety of foods and has marked likes and dislikes. One of the best methods for developing good food habits in children is, for the whole family to eat wisely. Mealtime can and should be one of the pleasant times of the day for the whole family.

FOOD HABITS OF EARLY YOUTH (10 to 14 years)

During adolescent growth spurt, nutritional requirement increases. There is increase in all nutrients. For girls, iron requirement increases with commencement of menses.

Good nutrition is very important for adolescent boys and girls. For girls it is of particular importance because in later life, maternal status affects the health of the child.

Studies have indicated that if nutritional requirement is met by adolescents through a balanced diet, then Indian adolescents are comparable to American children. But such adolescents belong to well-to-do families, where there are no economical constraints on food.

But this group constitutes a small portion of adolescent population. The adolescents from lower socio-economic group are much below the normal in height and weight and growth rate than their counterparts, due to poor nutritional status.

The FAO/WHO suggest that nutritional requirement of undernourished children should not be adjusted for their current body weight, but should be related to their ideal body weight for age. Such an allowance will provide some scope for catch-up growth. Although assumption has no experimental studies, a well designed school feeding programme can achieve this objective.

Good advice:

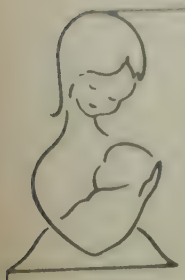
A professor who had taught for many years was counseling a young teacher. "You will discover," he said, "that in nearly every class there is a youngster eager to argue. Your first impulse will be to silence him. I advise you to think carefully. He may be the only one listening."

Thank Goodness!

"I'm so glad I finally am eleven years old" said Kamala on her birthday, to her mother.

"Why?" asked her mother.

"Well, when a grown-up does something dumb, people usually say, is acting like a ten-year-old!"



Bedwetting

A. Chitra Andrade, M.A., M.Phil., Ph.D.
Chittaranjan Andrade, M.D.

Aruna is 11 years old. Recently, she awoke in the early hours of the morning with the realization that she had lost control over her bladder in her sleep.

Bharat, aged five, wets his bed at night about once a week.

Carmilla, aged three, continues to bedwet almost nightly.

Involuntary, intermittent, inappropriate loss of bladder control is medically termed enuresis. Commonly, the symptom occurs only at night (during sleep), when it is called nocturnal enuresis. Enuresis is considered a problem only if it is age inappropriate (it is not usually diagnosed in children below the age of four), and frequent (seen at least once a month). It is termed primary if occurring in a child who has never gained bladder mastery, and secondary if developing in a child who had previously been 'dry' for at least a year — 80% of enuresis is primary.

The incidence of affliction varies with age; it is about 10-15 %in five year old children, decreasing to about one percent in adults. Boys are twice as commonly affected as girls.

There is a widely prevalent but erroneous belief that enuresis is due to psychological disturbance alone. While undoubtedly emotional causes (e.g. stemming from marital discord between the parents, problems at school, etc.) may play a role, today it is believed that delayed maturation (for genetic or other reasons) of urinary mechanisms, abnormalities (including infections) of the genitourinary system, or other medical problems, are responsible to a greater extent. In enuretics, abnormal brain electrical waves, abnormal sleep patterns and abnormal water regulation have been described around the hours of enuresis. The balance of evidence suggests that 'biological' factors are responsible for primary enuresis and 'psychological' factors for secondary enuresis, although both biological and psychological factors are frequently present together.

While enuresis almost always remits spontaneously, medical consultation can identify possible underlying medical problems. If found, these must be treated. If none are present, several lines of treatment are available. These include psychotherapy for the child and often also the parents, drugs (many effective types of which are available) and 'conditioning' (e.g. using a gadget the alarm of which awakens the child the moment a drop of urine touches the bedsheet; the child rapidly learns to awake to pass urine in the toilet before the time at which the alarm usually sounds).

A 'sun' (for a dry night) and 'umbrella' (for an enuretic night) calendar, maintained by the child, often helps facilitate 'sunny' spells and eventual cure. Bladder training, sleep interruption (to void), hypnosis and placebo therapy are other treatments that have been essayed.

Usually, several forms of treatment are concurrently employed; results are good, and within months most patients achieve progressively increasing control or even total relief; relapses often occur, but can be effectively handled.

★ Give praise and recognition for effort rather than achievement

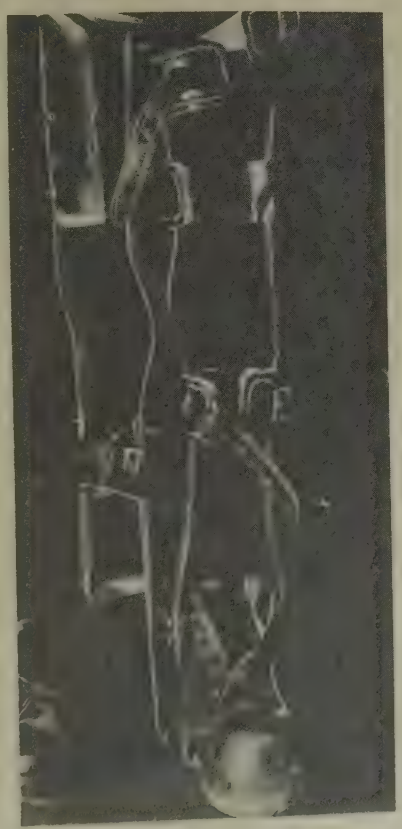
Unfortunately, praise and recognition are usually made available only for achievement, whereas they are most necessary for effort. If only those children in a group who show effort receive praise, the number who achieve results would be much increased. This is particularly necessary in the school where the teacher can improve or even rebuild the foundation for a child's self-esteem. The teacher must act on the assumption that every pupil has unrealised potential for development, if the appropriate stimulus and encouragement can be given.

Polio: The end in sight

In May 1988, representatives of 166 nations, meeting at the World Health Assembly in Geneva, took the historic decision to attempt to eliminate poliomyelitis from the planet by the year 2000.

In the industrialized world, the disease is almost eradicated (as recently as the 1950s, tens of thousands of cases of paralytic polio still occurred annually in Europe and North America). But in the developing world, polio still paralyses over 250,000 children a year and kills another 23,000.

Today, vaccines are also beginning to lift the burden of polio from Africa, Asia and Latin America. In the last twelve months, immunization has prevented approximately 220,000 cases of paralytic polio in the developing world.



A picture of the past ?

The World Health Organization's Expanded Programme on Immunization targets polio as one of the six major vaccine-preventable diseases. Only ten years ago, fewer than 5% of infants in developing countries were being immunized. Today, 55% of the infants born each year in the developing world receive three doses of oral polio vaccine by the age of 12 months. In countries such as Botswana, Brazil, China, Cuba, Egypt, Nicaragua, Republic of Korea, Saudi Arabia and Tunisia, 80%–90% of infants are already fully vaccinated against polio. Algeria, the Dominican Republic, India, Indonesia, Iran, Iraq, Kenya, Mexico, Pakistan, Tanzania and Turkey are among those confidently expected to reach the 80% mark by the year 1990.

In many countries, coverage has doubled or trebled in a six-month period through national vaccination days involving tens of thousands of volunteers. Others have taken a more gradual approach, building up routine vaccination services through the primary health care system.

One dark cloud on the horizon is the recent rise in drop-out rates in Africa south of the Sahara. Polio immunization normally requires three doses of the vaccine, and the drop-out rate is the percentage of those given the first dose who fail to turn up for the second or third doses. Going against the world-wide trend, which has seen a 25% fall in drop-out rates since 1984, the rate in sub-Saharan Africa has actually risen slightly from 36% in 1984 to 37% in 1987 (but against a much higher level of initial coverage). In some dozen countries the drop-out rate exceeds 50%.

The global elimination of polio, like that of smallpox, is technically feasible since the virus is transmitted by infected persons for only a few weeks and neither multiplies outside the human body nor transmits itself via animals. As with smallpox, a vaccine which is safe, effective, cheap, and simple to administer is already available. But unlike smallpox which was controlled mainly by immunizing the

close contacts of those infected — the eradication of polio will require maintaining high coverage levels (of the order of 90%) among children under the age of one year for some years even after no further polio cases are reported.

For all vaccines, a key to high and sustained levels of coverage — and low drop-out rates — is the involvement of political leaders, the media, community leaders, educators and private voluntary organizations. In the fight against polio, in particular, Rotary International has made an outstanding contribution, raising the staggering sum of $240 million in voluntary contributions through its world-wide "Polio Plus" programme. Just as important, thousands of Rotarians-often leaders in their communities-have become personally committed to the polio programme and brought influence, know-how and resources to the task.

UNICEF — The state of the world's children 1989

Medical News

Long-term Protection From German Measles.

The MMR (measles-mumps-rubella) immunization protects children from three childhood diseases. But is the immunization still in effect as these children reach childbearing age? A rubella infection during pregnancy puts the fetus at risk for congenital defects.

A follow-up of children immunized against rubella found that around 95 percent still had protection sixteen years later. **Journal of the American Medical Association.**

Diabetes and Congenital Malformations

Women with insulin-dependent diabetes have two to three times the risk of having a baby with congenital deformities. Abnormal blood-sugar levels play a part in this, but researchers believe that other factors — including maternal age at onset of diabetes and its duration, damage to blood vessels and nerves, and level of insulin doses — may also contribute to the increased incidence of malformation. **Journal of the American Medical Association.**

"Clean-Catch" Urine

A clean-catch sample is often a must for obtaining a urine culture. A girl's urethral area must be cleaned and the urine collected in midstream.

Alternatively, sitting backward on the toilet, which separates the labia from the urethra, was found to be as effective as the clean catch in reducing contaminants. **American Journal of Diseases of children.**

Silent Miscarriages

Women get pregnant and miscarry more frequently than previously believed. In a study of women trying to conceive, almost one third of all the pregnencies ended in miscarriage. About two thirds of those miscarriages occurred before the women even knew she was pregnant.

It's uncertain yet whether these figures apply to the general population, but if so it would mean that miscarriages are quite common. Fortunately, miscarriages don't seem to affect fertility. **The New England Journal of Medicine.**

Anorexia — Lack or Loss of appetite — Signs and Symptoms

Anorexia nervosa and bulimia are well documented among teens. But children as young as five have been diagnosed with these disorders.

Common symptoms among anorexics and bulimics are:

★ abnormal or severe weight loss.
★ refusal to eat, except for very small portions.
★ binge eating.
★ preoccupation with food.
★ vomitting.
★ denial of hunger.
★ excessive exercising.
★ distorted image of one's body.
★ absent or irregular menstruation (in girls who menstruate regularly)
★ abuse of laxatives, diuretics, emetics, or diet pills.
★ low sense of self-worth.
★ dental problems or periodontal disease (due to nutritional deficiencies)

Not all victims display all of these symptoms, so if parents notice any of these signs, they should contact a doctor or other resources for information on diagnosis and treatment. Left untreated anorexia and bulimia can lead to lifelong problems or death.

— Parents

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

Everything you wanted to know about convulsions

The group of doctors were Dr. B.R. Rama Rao, Dr. C.M. Balakrishna, Dr. M.S. Kumar, Dr. Gopalakrishna and Dr. B.M. Lava. They met a group of parents whose children had convulsions or "fits". The following is a summary of what took place.

Dr. Rama Rao:
Good morning, I am glad to see so many people gathered together. "Fits" or "Convulsions" or "seizures" are very common. They are often frightening but need not be so. You are welcome to ask questions.

Kamalamma:
My son Arun, three years old, had high fever and then he had fits. People say that children with high fever get fits. Is it true, doctor?

Dr. Gopalakrishna:
Yes, it is true. It is called a febrile (of fever) fit.

Kamalamma:
Is it due to brain fever?

Dr. Gopalakrishna:
No, it is not due to brain fever. It can come with sore throat, infection of the ear, infection in the chest and other causes. When the fever is high, some children get fits.

Venugopal:
Will the child get fits everytime the child has fever?

Dr. Kumar:
Not necessarily; rapid rise in temperature can cause fits or convulsions. Almost half the children do not have any recurrence. About 10 percent have multiple recurrences till the age of five years.

Kamalamma:
How can I prevent the fits coming on with fever?

Dr. Kumar:
See that the fever does not rise rapidly. Practise sponging the body with cold water. Dip a large piece of thick cloth or small towel in cold water and sponge the body. You can also give medicines to bring down the temperature. Paracetamol is safe; the dose must be regulated, according to age.

Venugopal:
Do all children with fever get convulsions?

Dr. Kumar:
No, about three percent of the children are likely to get fits associated with fever.

Venugopal:
Is this type of convulsions dangerous?

Dr. Kumar:
No, though terrifying to the parents, these fits are not dangerous, unless prolonged.

Krishna:
Are these children likely to be mentally handicapped?

Dr. Kumar:
No, there is no increased incidence of mental handicap or other behavioural problems in these children, now or later.

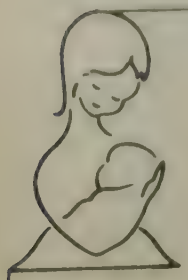
Venugopal:
What would you advise a parent whose child had a fever convulsion?

Dr. Kumar:
I would say, do not panic; it will not harm the child; it is quite common.

Kamala:
Do fits occur in the newborn?

Dr. Balakrishna:
Yes, I will tell you about a patient. Mrs. R. delivered a male baby weighing 3.2 kg. Her pregnancy was normal but she had a difficult and prolonged delivery. Her baby did not breathe at once, was blue at birth and required help. After about 7–10 minutes (according to her), breathing was established and the child was apparently normal till 16 hours after delivery, when the child developed convulsions and was brought to the hospital.

Kamala:
Is the condition serious?



Dr. Balakrishna:
Yes, Convulsions in the new born are a sign of significant illness, especially of the nervous system. There can be brain damage.

Venugopal:
How do convulsions cause brain damage?

Dr. Balakrishna:
Convulsions interfere with cell multiplication in the brain. This results in impaired brain growth.

Venugopal:
Why did this baby get convulsions?

Dr. Balakrishna:
Since breathing was not established promptly at birth, the baby suffered brain damage due to lack of oxygen. The brain damage led to convulsions. The medical term for it is long (Ischaemic hypoxic encephalopathy).

Kamala:
Is this the only cause of convulsions in the newborn?

Dr. Balakrishna:
No, there are other causes. I will name a few: low blood sugar (hypoglycaemia); low blood calcium (hypocalcaemia); infections of the brain (like meningitis); defects in the development of the brain; bleeding into the brain (intracranial haemorrhage).

Kamala:
Will the baby of Mrs. R. be normal?

Dr. Balakrishna:
This is a most difficult question to answer. Atleast half the number of such children will have moderate to severe impairment of the nervous system. Early detection and efficient management can result in better outcome.

Vasantha:
My child is nine months old. Since two weeks, the child often cries, stops breathing and has something like fits. What is it, doctor?

Dr. Gopalakrishna:
Yes, some children stop breathing and become blue in the face, following crying. The child becomes stiff, lose consciousness and then has jerking movements of the body. The child, on its own, becomes normal and alert in a few seconds to minutes.

Vasantha:
Is it a fit? What should I do?

Dr. Gopalakrishna:
This is known as breath holding attack. Some children have it between the ages of six months and two years. Do not panic, do nothing to the baby. The baby will get over this problem after two to three years. It is not a fit or convlusion or epilepsy. It does not require any treatment.

Krishna:
What is epilepsy? My eight year-old boy is said to have epilepsy.

Dr. Lava:
Convulsive disorders which are recurrent in nature are called epilepsy.

Krishna:
When does it occur?

Dr. Lava:
It can occur at any age.

Krishna:
Is it contagious ? Can it spread from one child to another?

Dr. Lava:
Certainly not.

Krishna:
My son had two major convulsions. He is on treatment for the past two months. I want to ask you whether it will recur again?

Dr. Lava:
It will not, if you give him regular daily treatment. Avoid his experiencing emotional disturbance. Avoid sleeplessness.

Krishna:
My boy sleeps too long. Does the medicine cause excess sleep? Does it affect alertness?

Dr. Lava:
Yes, in the beginning. Soon he will develop tolerance and will be as alert as anyone else.

Dr. Kumar:

Sometimes the child may become even hyperactive.

Krishna:

How long should the boy continue to take the medicine?

Dr. Lava:

Ordinarily, he should take the medicine for atleast three years after the last fit.

Krishna:

Would he be able to concentrate and learn well at school?

Dr. Lava:

Some drugs like phenobarbitone cause some amount of inattentiveness and learning disturbances. But it is reversible after the treatment is stopped.

Krishna:

What will happen if he misses a dose of medicine?

Dr. Lava:

Never allow that to happen. If he does, he can have a lot of problems with repeated convulsions. He can miss a meal but not medicine.

Krishna:

My son wants to be like other boys of his age and to play games. Should he be protected?

Dr. Lava:

In the beginning of the treatment, yes, he needs to be protected. After daily regular treatment for six – 12 months, he can participate in games without worry. Supervision is necessary while swimming.

John:

Are there any side-effects to these drugs?

Dr. Lava:

Both mild and more severe side-effects can occur. Mild ones are rash, nausea and vomiting and stomach disturbances. The more severe ones are liver damage, anaemia and bone marrow depression. A patient on long term therapy should visit the doctor frequently, especially in the initial stages.

Nathan:

What should we do when a patient gets an attack?

Dr. Lava:

As soon as the patient has a fit, make him or her lie down on a flat surface. Turn the head to one side. This will prevent aspiration of secretions or food into the lungs. Loosen the clothing especially at the neck. Avoid overcrowding. Open the windows for better circulation of air. Do not pour any liquid into the mouth. Fits usually stop within a few minutes.

Nathan:

What about diet? Will a change in diet help?

Dr. Lava:

No need. The patient can have a normal diet. In severe forms of epilepsy which are difficult to control with drugs, a special diet (ketogenic diet) can be tried. It has more fats, less carbohydrate (starch) and optimum amount of proteins.

The diet is difficult, expensive and monotonous. Success depends on the ability of a mother to weigh out the foods and on the complete adherence to the diet prescribed.

Krishna:

What general information would you give to the patient and parents?

Dr. Lava:

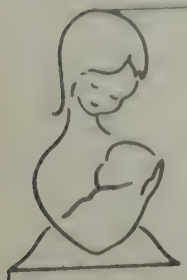
The patient and parents need help to understand the problems of seizures and their management. Children, even as young as three years, co-operate well. Encourage normal living. Children should engage in physical activities including sports and games, appropriate to their age and social group.

Prathap:

My son had a fainting attack while in school the other day. He never had such an attack earlier. Is it a fit?

Dr. Gopalakrishna:

Some children fall to the ground after prolonged standing. They do not respond for a few seconds. They get up soon and are normal. This is only fainting and not a fit.



Prathap:
Why did he faint?

Dr. Gopalakrishna:
There are many reasons. Long standing, fasting, inadequate food, low blood sugar, sudden fright and many others can cause faints.

Prathap:
Will it happen again?

Dr. Gopalakrishna:
Difficult to say. It can. Please get your son examined by a doctor.

Organiser:
We are thankful to all the doctors and other participants for the instructive session. I am sure that the session has clarified many points regarding fits, convlusions and seizures that we see often.

Beware Balloons

Inhaling an uninflated balloon or pieces of a broken balloon is the leading cause of suffocation death of children.

An uninflated balloon is easily sucked into a child's airway. In trying to blow up a balloon, for example, a child may keep it in his mouth while inhaling deeply between blows and accidentally draw the balloon down his throat. Accidents also occur when children chew or suck on uninflated balloons. One child died when she fell from a swing while sucking on a balloon. As she hit the ground she inhaled sharply in a reflex action, sucking the balloon down her throat. Pieces of a broken balloon are equally dangerous. They are fun to chew on or to stretch across the mouth and suck in or blow bubbles in. Unfortunately they're also easily sucked into the airway. And since balloons are made to prevent air from passing through them and because they mold easily to the contours of the throat and adhere there, they are deadly in the breathing passage.

No one is suggesting that balloons be banned; however, to be safe, adults should:

★ always blow up balloons for their children.

★ supervise children under the age of six who are playing with them.

★ warn older children of the danger of sucking or chewing on balloons.

★ make sure that all the pieces of a broken balloon are picked up and safely thrown away.

— Parents

The New Paediatrician

The major goal of child health care today is no longer aimed at only saving lives but also directed towards helping the surviving children reach their full potential. This can best be done by motivating children through their parents and family to practice health promoting and health facilitating life-styles, controlling vulnerabilities and supporting resources of the child, the family and the community. The new competence, the paediatrician of tomorrow must develop are also along the direction of biosocial and developmental aspects of paediatrics -

Aurora P. Asauza
The Philippine Journal of Paediatrics,
35 (1): 1, 1986 as quoted in
World Health Forum, 10 (1), 65, 1989

Begin in Schools

Ms. Liv Ullman, the highly successful Norvegian actress, was interviewed on behalf of WHO. One of the questions asked was on how to bring about a change when even governments are not sensitive to the great divide between the "haves" and the "have nots". Her answer: "It is easy to feel frustrated because the question is so complex. But I think you have to start in schools and motivate children to adopt a new ethical code. Even philosophy as it is taught today is still unconcerned with current problems including development and it has nothing to do with health. Yet, in the end, health is spiritual"

World Health Forum, 10(1), 92, 1989.

Light a light for those in darkness

Dr. Louisa Emanuel

Every 14 minutes a child goes blind due to lack of Vitamin A. Every 14 minutes another child's life is on the brink of ruin. Blindness from a manmade deficiency disease means that —someone has failed somewhere. Whom do we blame? The ignorance and carelessness of parents or the community that has not been supportive of the poorest and the marginalized — or the doctors, the whole medical set up, the state, the Government that has failed to make possible basic health care where the need is most urgent.

Why should we have more than 40,000 children going blind every year due to lack of Vitamin A in India alone? WHO estimates that every year 100,000 to 200,000 children suffer from nutritional corneal ulceration and only a quarter of these children recover with reasonable eyesight. Another quarter go either partially or completely blind, while the remaining half die in the acute stage of the illness.

Vitamin deficiency occurs when body stones are exhausted and supply fails to meet the body's requirements. This can result from either

— a low dietary intake
— inteference with absorption from the small intestine
— rapid loss of Vitamin A
— Disturances in the synthesis and transport of Vitamin A

Children most often affected do not suffer from single dietary deficiencies, they nearly always have protein energy malnutrition (PEM) as well. In this state of under-nutrition a child easily succumbs to recurrent infections, diarrhoea, respiratory infections and measles. The latter being in India a commonly fatal infection, Vitamin A deficiency leading to Xerophthalmia has been associated with these infections.

Blindness from corneal ulceration due to Vitamin A deficiency can cause extreme personal suffering and economic loss all over the world. The cause of nutritional corneal ulceration are very complex but the remedy is simple. A balanced diet of cheap nutritional foods which even the poor can afford, would greatly reduce the incidence of this disease. Immunisation against measles could go a long way to probably eradicate blindness due to lack of Vitamin A.

Food being the first and the most important dietary source of Vitamin A we need to familiarize ourselves with the locally available foods.

Breast milk being BEST, an infant gets his requirement of Vitamin A from his mother up to the age of six months.

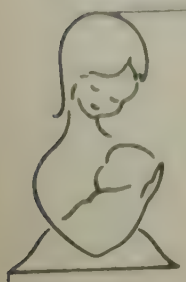
For the non-vegetarian, liver is the best source of Vitamin A and for the strictly vegetarian, milk products and plant foods containing the carotene pigment are also very rich sources of Vitamin A. The best source is red palm oil, others being green leafy vegetables and orange coloured fruits and vegetables like caorrots, mangoes and papayas. Unfortunately rice, the staple food of the poor contains little or no Vitamin A.

Children are at greater risk from Vitamin A deficiency than adults. The Vitamin A requirement per unit of body weight is much greater for a child than for an adult. Signs of deficiency are far more common in children with inadequate Vitamin A in their diets but extremely rare in adults.

The daily recommended allowances vary with age and sex.

Signs and Symptoms of Vitamin A deficiency in the eye

Xerophthalmia (literally 'dry eye') is used to cover all ocular signs of Vitamin A deficiency. Originally an evolution from early to later stages of xerophthalmia was presumed with night blindness as one of the first clinical signs of Vitamin A deficiency and blindness ulceration and Keratomalacia, an end stage. However recent studies have demonstrated



that the severe forms of the disease can manifest quickly without an obvious sequential progression. Xerophthalmia Classification.

Night Blindness

Vitamin A is important and essential for the light sensitive rods in the retina to function properly, Vitamin A deficiency produces poor dark adaptation and poor night vision.

Conjuctival Xerosis

The bulbar conjunctive especially the exposed parts undergo changes. Dryness causes it to lose its normal lustre. Increased pigmentation gives it a dirty brown colour. Vitamin A deficiency cannot be diagonised on this alone. However conjunctival Xerosis can be fully cured with Vitamin A treatment.

Bitots Spots

A Bitots spot is a small plaque on the bulbar conjunctiva. A Bitots spot is a very obvious sign and when other conjunctival signs are present is very likely due to Vitamin A deficiency.

Corneal Xerosis

It is an extension of the conjunctival signs onto the cornea. It is a much less than Conjunctival xerosis but a more specific sign of Vitamin A deficiency. The surface of the cornea looks dull, rough and irregular.

Corneal Ulceration/Keratomalacia

A time when emergency treatment is needed. There are causes of corneal ulceration when conjunctival xerosis is present and if both eyes are involved it is very likely to be due to Vitamin A deficiency.

Keratomalacia is the last and most severe sign of xerophthalmia. A mass of white or yellow-gelatinous necrotic matter replaces the normal cornea. Destruction of the eye leaves a person blind.

Corneal Scars

Corneal scars are usually in the lower part of the cornea and usually in both eyes. Corneal scars in a malnourished child tells the sad story of Vitamin A not reaching the poorest of the poor.

Xeropthalmia Funds

Vitamin A deficiency produces a characteristic change in the retina. These retinal lesions appear as yellow spots.

Blindness as the result of Vitamin A deficiency speaks of a world where the poor are voiceless with crores of rupees going into the production and selling of non-essential drugs like tonics and the likes. Vitamin A an essential drug is not available not even when you are willing to pay for it. The need for Vitamin A is growing with every new birth yet the production and availability of Vitamin A has fallen.

Vitamin A, just a capsule a day when needed could prevent one little child going blind.

The daily recommended allowances vary with age and sex.

Young Drinkers

Children are being exposed to alcohol at an alarmingly early age.

A recent survey of more than 500,000 U.S schoolchildren revealed that 26 percent of the fourth graders questioned had tried alcoholic beverages.

The average age at which kids try alcohol is twelve years old, but many have their first drink as early as age eight.

Fewer than half of the fourth, fifth, and sixth grade questioned considered alcohol a drug, and 21 percent saw wine as a drug. **Medical World News**

for children

A child was over heard praying by his mother, "Oh, God, please make Bombay the capital of India". He was heard repeating it again and again. Finally his puzzled mother asked him, "Why are you praying to God, to make Bombay the capital of India?"

The child promptly answered, "Because in my exams I wrote, Bombay is the Capital of India"

Jaideep Singh, nine years
Hyderabad Public School

Importance of Vitamin A

Susan D Eastman

Vitamin A is required by the human body for various functions. The best known is for maintaining good vision. It is also important in growth and reproduction. It also helps in the maintenance of epithetral cells and immune properties and hence in our defence mechanisms against infections.

Vitamin A is stored in the body. Its deficiency occurs when the body stores are exhausted and supply fails to meet the body's requirement. This condition can result due to different causes — low dietary intake is a major cause. The deficiency is manifested mainly by the eye signs which is denoted as Xerophthalmia. It is considered as a reliable criterion in identifying Vitamin A deficiency. Xerophthalmia means dry eye. It covers all the eye signs of Vitamin A deficiency.

1 Night blindness	— mal-adaptation to dim light
2 Conjunctival Xerosis	— drying of the conjunctiva
3 Bitot's spots	— foamy or cheesy patches forming on conjunctiva
4 Corneal Xerosis	— a hazy or granular surface, a pebbly dryness apparent on the cornea.
5 Corneal ulceration	— ulcers appear on corneal revatomalacia surface which progress rapidly.
6 Corneal scar	— scarring associated with previous Xeropthalmic condition.
7 Xerophthalmic fundus	— retinal lesions

Pre-school children at risk:

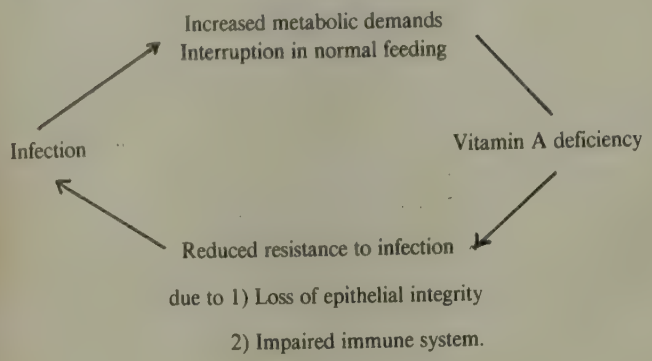
Xerophthalmia is not restricted to any age group. The pre-school child is considered most at risk of the deficiency. Mother's milk can contain enough Vitamin A to maintain adequate levels of Vitamin A in infants upto 6 months of age, but if the nutritional status of the breast feeding mother is low, the status of the infant is also low. Also it is a common practice in our country that colostrum which is rich in Vitamin A, as well as antibodies to protect the child, is considered harmful to infants and hence not given. Besides these, when a child is weaned, the food intake is often inadequate and inappropriate. The main reason for discontinuing breast feeding is another pregnancy. Hence the nutritional status of such infants is low. Such a child, when he/she is ill, his/her food intake is often suppressed due to lack of appetite and cultural practices. On the other hand, an ill child requires additional Vitamin A to fulfill the metabolic needs of the body. Hence illness and Vitamin A play a synergistic role with each other.

Measles and Vitamin A:

Measles is one of the illnesses that has devastating effect on children in the developing world. Measles complications include diarrhoea, pneumonia and blindness. Xerophthalmia surveys in Bangladesh and Indonesia have demonstrated the association between measles and Vitamin A deficiency. Typically measles is accompanied by eye signs of Vitamin A deficiency. Although children frequently recover, they fall victims to post-measles diarrhoea, broncho-pneumonia and corneal destruction.

Studies in India too suggest that chronic nutritional deficiency of Vitamin A may affect the structural integrity of the epithetral tissue with cornea and elsewhere which will compound the impact of measles virus and secondary infection.

It seems clear that once the cycle of Vitamin A deficiency and infection commences, they impact on each other. The following diagram would better illustrate this.



In India, considering the importance of Vitamin A and its role for the well-being of children, the government has launched a Vitamin A programme. Vitamin A capsules are given orally to high risk children.

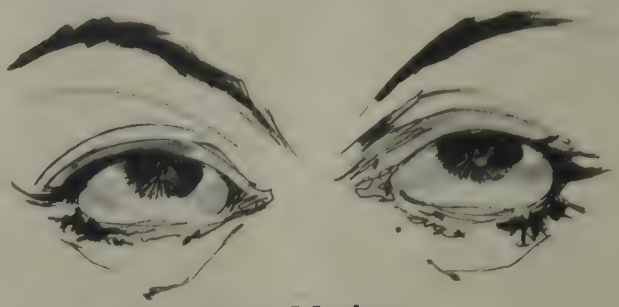
Courtesy: Vitamin A deficiency and Xerophthalmia Susan D Eastman — a UNICEF Publication, 1987.

of children

One day a child was eating his ice-cream, when his ice-cream fell down. He bent to pick it up and was admonished by his mother not to pick up fallen things, as they would be dirty. "We shall buy another ice-cream", she told him. The next day his father tripped over a stone and fell down. His mother went to help him up. The child said, "Don't pick fallen things. Let's go and buy another daddy".

Jaideep Singh, nine years
Hyderabad Public School

Do you know?



Your child's Eyes Mothers

★ The eye is one of the first sensory organs to be formed at the second month of pregnancy.

★ You should eat nutritious food with plenty of dark green leafy vegetables, yellow coloured vegetables and fruits.

★ As far as possible do not take any medicine during early pregnancy as it may prove dangerous to your child.

★ You must make sure that baby's eyes are cleaned properly soon after birth.

★ Breast feed your baby soon after delivery. Breast milk is rich in Vitamin A which is good for the child's eye sight.

★ Take your child to an eye specialist if there is any watery or pus-like discharge. Do not neglect this.

★ Avoid use of kajal or surma.

★ Give your child a balanced diet with foods rich in Vitamin A.

★ At eight weeks the child should be able to recognise familiar faces (Mother).

★ At three months, the child should be able to fix his gaze to an object and smile on seeing you.

★ At six months, you should look for signs, if any, of crossed eye (squint). Consult an eye specialist if you have doubts.

★ At nine months, your child should be able to see new objects thrown near him. Spread some sweets behind his back when he is being examined. Then turn him on the table. See whether he is able to recognise the objects.

★ Take your child for an eye check-up at three years or before he goes to school.

Social Welfare
January-February 1990.

Childhood's bogeyman — Diarrhoea

Dr. Suneeta Singh

I was about to close the health centre for the evening when Armugam's mother came to me.

"Ammaji" she said "Armugam has diarrhoea again."

"Diarrhoea again? How often has he been passing stools?"

Armugam's mother prevaricated, "So often that I have barely enough time to wash out his clothes when I have to clean him up again."

"How often since the morning?". I asked again.

"About eight times — no nine times since he woke this morning. And really watery this time — not just soft like the last time I had come to you. You said then that little ones often have stools like that normally, but this time they smell very bad too".

A conversation very similar to this will be recounted on an average by every mother in India at least 12 times in a child's life. Some will have more episodes than others, but a child will have on an average, two to three episodes of diarrhoea every year of his life till he is five years old. No child should have to pass an initiation rate of 12 or 15 bouts of diarrhoea to make it to his fifth birthday — if he makes it at all. With three children dying of diarrhoea every minute in India, his chances are not so very good at that.

What then is Diarrhoea?

Most paediatricians agree that when a child passes more than three very loose, watery stools in a day the child has diarrhoea. In a child under one year however, even 10 or 15 stools are considered normal so long as they are semisolid and soft in consistency. One episode of diarrhoea lasts three to seven days if not complicated by other problems.

Most diarrhoeas can be handled at home if some simple rules are followed. On the other hand, dysentery with its foul-smelling stools accompanied by pus and blood, must be treated by a doctor from the outset.

How can Diarrhoea be prevented?

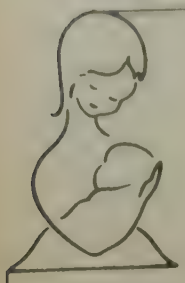
Diarrhoea is in most cases due either to the poor quality of water that is drunk or to poor personal hygiene.

If the water supplied in any given locality is not clean (which can be judged grossly by the rate of diarrhoea occuring in that locality) it is best to boil or filter all the drinking water used in the home. Personal hygiene is the other significant factor. Often diarrhoeal germs are transmitted to food or water by unclean hands or flies. All cooked foods must be kept covered and hands must be washed before cooking and before eating food.

What makes Diarrhoea dangerous?

In a word, complications. Firstly, diarrhoea leads to increased loss of water and salt from the body. If this loss is not made up, the child becomes dehydrated and can even die. Secondly, the child loses his appetite and refuses to eat. And since there is a widely held belief that the more a child eats the more the diarrhoea, the child is starved in an effort to stop the flow. When this cycle is repeated even a few times, the child becomes malnourished. Malnutrition further lowers resistance not only to diarrhoeal disease but also to other infections and a vicious cycle of disease — malnutrition — disease is set up. Dehydration and malnutrition are the main dangers of diarrhoea. It is these, we must seek to prevent if we are to prevent deaths due to diarrhoea.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad–500 003. Ph: 841610



Most diarrhoeas are caused by viruses —germs that cannot be killed by antibiotics or any other medicines. So, antibiotics are useless. The most important thing in these cases is to prevent the complications of diarrhoea that lead to death. Only some diarrhoeas are due to bacteria — these are susceptible to antibiotics. But in these too, the same complications could cause death.

How can these deaths be prevented?

The point of course, is to prevent dehydration before it happens. As soon as the child develops diarrhoea, the child must be given extra fluids in any form. Any drinks that are available at home (Home Available Fluids, HAF) and that the child enjoys (remember we are talking of an ill child-irritable and cranky) be it simple water, lassi, lemon juice, or soup — should be given to the child often and in adequate quantities. Some easy measures to remember are that for every stool passed, you need to replace:

15 ml or 1/3 a medium katori	— for zero to one year old
100 ml or 1/2 a glass	— for one to six year old
200 ml or one glass	— for six to 12 year old

If the child is allowed to drink freely and an effort is made to make up with fluids available at home, there is no reason why he should fall prey to the risks of dehydration.

Malnutrition, the other great danger, can be avoided by the necessary expedient of patience. It requires great patience to coax a child who has lost his appetite to eat, but eat the child must. Food, made to the child's liking and coaxed into his often reluctant mouth is the only protection against malnutrition. If the child is still on breast feeding it must be continued. Small meals, frequently given, may sometimes be the only way to get the requisite number of calories into that young body.

When the child's loss of salt and water are not made up as soon as he loses them, he or she develops a gap between losses and intake. It is in this condition that the child is said to be dehydrated. This gap must be made up fast. For this purpose the World Health Organisation recommends the use of standard Oral Rehydration Salts (ORS). ORS is available at all health centres. One packet of ORS should be dissolved in one litre of clean water. Should less water be used to dissolve the salts, a very concentrated solution would result. This could be dangerous to the child's system. Each lot of ORS solution prepared in one litre of clean water should be used up the same day. Any ORS solution that remains should be discarded and a fresh lot made up the next day. If ORS is not available, a simple formulation that can be made at home is:

Table salt	3.5 gm	2/3 tsp level
Meetha soda	2.5 gm	1/3 tsp level
Clean water	one litre (two full milk bottles)	

Another formulation that is highly recommended is rice ORS. Rice-ORS is in some ways better than plain ORS because it is seen as a food. It also decreases the frequency of vomiting and of stools in diarrhoea and also the total duration of the illness (Box 1).

The important thing to remember is that any store-bought formulation such as ORS is designed to correct the gaps between intake and losses. Once the gap has been filled, these should be stopped. The continued use of ORS after the correction of dehydration could lead to excessive salt accumulation in the body. Home available fluids, on the other hand, should be continued till the diarrhoea has ceased.

When should you take your child to the doctor?

The child should be taken to the doctor if the diarrhoea continues for more than two days. Also if the child refuses to take fluids while continuing to pass watery stools he or she stands the danger of developing dehydration. Dehydration should be suspected if the child grows increasingly drowsy, listless and irritable. The skin grows less resilient, the eyes look sunken and the mouth becomes dry. If this condition develops in a child with diarrhoea, especially in one who is already taking home available fluids, the child should be taken at once to a doctor for assessment and advice. (Box 2).

Diarrhoea is a bogeyman, carrying away three of our children every minute for the lack of a glassful of

water and a fistful of salts. It is about time to call his bluff.

Box 1

HOW TO MAKE RICE-ORS

(Rice–ORS should only be given to children over three.

Ingredients:

Rice flour	25 gms
Table salt	1.75 gms
Meetha soda	1.25 gms
Water	550 ml.

Method:

Mix 25 gms of rice in 50 ml of water for about 10 to 15 minutes before grinding. Grind the soaked rice. Add the rest of the water and boil stirring constantly. When the mixture has boiled, add the salts and stir thoroughly Cool before feeding.

Box 2

DANGER SIGNALS IN DIARRHOEA

High grade fever
Blood or mucus in stools
Severe undernutrition
Not able to retain orally
No urine for six hours
Frequent vomiting
Very dry sunken eyes
Very sleepy
Unconscious or having fits
Breathing very fast and deep

Verbal abuse

Effective parental communication is thought to be one of the most important factors in a child's ability to develop a positive self-image. If perental communication is consistently negative or critical, however, the effect on a child can be very damaging. Verbal child abuse is even more likely to cause a negative self-image than physical abuse.

While professionals find it difficult to define verbal abuse, some suggest that it consists of attacking the child and his basic worth. Expressions like "I wish you were never born" or "you are stupid and lazy" have been shown to affect children deeply and to make them feel that they are essentially worthless. Such feelings may actually contribute to later delinquent or self-destructive behaviour. Positive discipline and reprimands involve criticizing the action, not the child. When a parent says "what you did was wrong" it does not damage a child's self esteem the way his saying, "you are clumsy" or "you are mean" might.

— Parents

Smooth, Round, And Deadly

Balls are arguably the greatest toys invented for children, but for kids under five, small balls can be deadly. Death has generally occurred when a ball the child was mouthing slipped into the throat and blocked the airway. There is now concern that some large round toys and toy parts also present a choking hazard and not just to children under the age of three but to older children as well.

For that reason, you should teach children of all ages that they should never put a small ball — or any other smooth, round object — in their mouth, and keep small balls and marbles away from toddlers and infants altogether. Parents with different aged children must be particularly careful to make sure that older children don't leave jacks, balls, marbles, etc., where toddlers can reach them. Parents should also take the time to warn sitters, relatives, and any other care-givers of the danger.

When a child understands a commercial's purpose is to persuade her-or Mom-to buy something, she is less likely to want the product. So take the time to explain commercials to your child. Point out the techniques that make a product desirable, such as the bright packaging and smiling actors. Watching and discussing television ads together can help your child become a sensible consumer.

— Parents

Brain fever

Janaki Murali

Japanese Encephalitis or brain fever as it is more commonly known is a common occurrence especially in the southern states. The viral epidemic took a heavy toll in 1978 with the mortality rate 25 per cent in Kolar alone. Surveys between 1955 and 1972 had revealed that the virus was particularly high in the southern states of Andhra Pradesh, Tamil Nadu and parts of Karnataka. The Japanese epidemic though is not restricted to the south alone, the dreaded disease has claimed its victims in Assam, Uttar Pradesh and Manipur.

In 1981 1,258 persons had died of the disease. In Karnataka 75 died, in A.P. 367, Assam 375, U.P. 533, T.N. 38, Bihar 11 and Manipur five.

The virus is seasonal and rural based, according to Dr. H. Krishnamoorthy, a corporation health officer in Bangalore. It is predominant in paddy cultivation areas, probably because of the stagnant water which becomes a breeding ground for mosquitos. Pigs and water birds and accumulating garbage are cited as reasons for the rise in the disease. Killing frogs for export is cited as one possible reason for the rise in the disease.

"In a young piglet the virus particles multiplies from 10 to 20 particles to millions in a matter of 24 hours", says Dr. Krishnamoorthy. The piglet may look dull or listless but otherwise appears normal. The culex vishnuvi complex mosquito transmits the disease from the piglet to man — usually children below 10-years-old. Although 90 per cent of the affected in Karnataka are children, in Andhra Pradesh several adults were struck by the disease. Strangely the disease is not transmitted by eating the meat of the piglets, nor is it transmitted from child to child. The only way the disease spreads is from pig-mosquito-man.

Another strange phenomenon of the disease is that out of 10 children only one gets infected. The other nine may have developed subclinical infection but may never get the disease. Another mystery is that usually there is not more than one case from one village and not more than one from each family. Even among the effected, about 30 per cent succumb, 30 per cent survive to be disabled for life and the rest recover. Cases brought in early have a better chance of recovery.

There is no cure for encephalitis and doctors treat only the symptoms. Medical experts are also doubtful whether the vaccine which has to be acquired from Japan will really help as the virus strains show different strains each year. "The behaviourial patterns of the virus have changed," says Dr. Krishnamoorthy. "We'll have to develop our own vaccine. Medical personnel feel that even the indigenous vaccine should be administered three months in advance of an expected outbreak and should cover 90 per cent of the population which is not possible.

Field trials of the indigenous vaccine were going on and two million doses of it per year were expected to be available. The Vani Vilas Hospital used to run a public information cell about the disease to clear misconceptions of the disease, during an outbreak of the disease.

Symptoms of brainfever usually are headache, vomiting, loss of consciousness, memory failure, convulsions, leading to coma. Fever ranges from 100 degree Farenheit to 107 degrees Farenheit. Unfortunately there is no quick method of diagnosis.

While we wait for a vaccine to be made available and a cure to be found, other methods of controlling the epidemic have to be taken up. Some of the suggestions are to move the pigs from areas of populations; ensuring mosquito proof piggeries; eradication of mosquitos and better sanitary conditions. In Bellary in 1987 about 900 pigs were gunned down to the protest of pig rearers. In Bangalore, the corporation has issued a notification to pig owners to move their pigs from city limits. But whether moving the pigs from city limits would suffice is doubtful, as this would only infect a village nearby, according to Dr. Krishnamoorthy.

Low cost balanced diets for north Indian palettes

The general pattern of diet in Uttar Pradesh and the Punjab in the north differs in certain respects from that of the south. The menus suggested here can be used by people belonging to these regions to provide cheap and nutritious menus. Meant for the low-income groups, cost of the food per adult won't be more than Rs. 1.75 per day.

Menus suggested are based on the following foodstuffs: 425 g of cereals, 70 g of pulses, 100 g of green leafy vegetable, 75 g of non-leafy vegetable, 30 g of oil, 30 g of sugar or jaggery, 115 of milk and 30 g of fruits. The calorofic value will work out to about 2400 with a protein intake of about 60–70 per day.

For those who can afford the extra cost, some improvements could be made, the meal costing then Rs 2 to Rs. 3.00 a day: Retain cereal intake to 400 g, add an egg a day, increase milk intake to 200 ml from II5 ml a day and add 30 g of meat if non-vegetarian.

The daily diet should consist of two principal meals and one light meal for breakfast. One item from the breakfast list with tea or coffee with milk and sugar and one item each from the three sections for the two meals with buttermilk (equivalent to II5 ml of milk) with atleast one principal meal should from an ideal diet. Curd or milk could substitute the buttermilk.

Breakfast

—wheat porridge or wheat pulse ladoo

—khicheri or dosai or besan omelete

—pakodai or potato gulam jamun or calabash cucumber halwa

—aalu chole or green ladoo or khaman dhokla

—marunda or puha or sweet potato pura or pura

—fruit chaat or sprouted green gram with jaggery or sprouted green gram

Meals

A	B	C
Roti or chappaties from wheat or Bengal gram, jowar, bajra or maize or rice	Dal, mint chutney & veg bhujia,	One ripe banana or orange or guava
don't use the same cereal for both the meals	Dal with calabash cucumber and or orange charla	
	Curry, green leafy vegs bhurjee	
	Vadian and turnips	
	Rajmah and raita	
	Dal, green leafy vegs, veg bhujia	
	brinjal bhurtha and dal, rape leaves ratia	

by children

A Nursery child was asked to learn his alphabets by his teacher. He went to his mother who taught him the ABC while turning the grinding stone. Then he went to his father who while turning the pages of his newspaper mouthed the alphabet. He then went to his elder brother who was busy practising his kung-fu before a huge poster of Bruce Lee. He taught his younger brother the alphabet while aiming a kick in the air.

The next day the child recited the alphabet, incorporating all the actions that he learnt along with the alphabet from his mother, father and brother, ending the alphabet with a well-aimed kick at his teacher.

Kashyap Murali, seven years
Satyam Public School

Low cost balanced diets for south Indian palettes

Rice is the staple cereal of the south, but an attempt has been made here to replace part of the rice with wheat, millets and tubers.

These menus are mainly meant for the low income group, they have been so framed that the number of courses per meal is minimal and the cooking procedures are simple. The cost per day per adult is about Rs. 1.95. The menus suggested are for an adult and are based on 425 g cereals, 70 g pulses or fish, 100 g of leafy vegetables, 75 g of non-leafy vegetables, 30 g of oil, 30 g of sugar or jaggery, I55 g of milk and about 30 g of fruits per day. The calorific value will work out to about 2400 with a protein intake of about 60-70 g per day.

For persons who can afford the extra cost, some modifications are suggested: the cost would then work out to about Rs. 2.50 to Rs. 3.00 per day.

The cereal intake could be retained around 400 g; an egg could be included; and milk could be increased from 115 ml to 200 ml for vegetarians and 30 g of meat or fish could be included for non-vegetarians.

The daily diet should consist of two principal meals and one light meal for breakfast. One item from the breakfast list with tea or coffee with milk and sugar and one each from the three sections for the two meals with buttermilk (equivalent to 115 ml of milk) should form an ideal diet. Curd or milk could substitute the buttermilk.

Breakfast

—wheat porridge or wheat-pulse laddus or tapioca porridge

—Idli or rava idli or idiappam with chutney powder

—Puttu or pongal or uppumma or paniaram

—Dosai or maida dosai or ragi dosai

—Sundal or vadai or bajji or pakoda or steamed puffs or tapioca gulam jamun

—Fish cutlets or tapioca — fish curry or tapioca-fish dosai or tapioca fish chappatis or chops.

Meals:

A	B	C
Rice or ragi or Jowar or bajra or varagu or topioca cooked	Sambhar & Vegetable Chutney	One ripe banana or one mango
Roti made from wheat	Vegetable soup and pulse chutney	or about half a papaya
Ragi, jowar or bajra	Veg curry and veg kootu	
Don't use the same cereal for both meals. Include pulses fish with topioca	Pulse salad & veg soup	
	Pulse powder & veg curry	
	Fish curry & Veg soup	
	Any other flesh foods may included for non-vetetarians **include daily one leafy veg like amarnath, mint, agathi. tapioca**	

Three liers were trying to outwit each other in lying. The first one said, "We need ten blankets to sleep in our country. It is very cold". The second one said, "oh that's nothing. In our country we need 100 blankets to protect us from cold". The third one not to be outwitted said, "in our country it is so cold, that when a lamb jumps over a fence, it is frozen half-way through".

The other two could not stomach such a blatant lie. They said, "The law of gravity should stop that".

The third one retorted immediately, "The law of gravity is also frozen in our country".

Jaideep Singh, nine years
Hyderabad Public School

Poisoning in Childhood

Dr B G Gopalakrishnan

Ingestion of harmful substances is a frequent occurrence in childhood.

Childhood poisoning is mostly accidental (unintentional). Occasionally in the older children it may be suicidal (intentional), we have also to think of homicidal poisoning.

Accidental poisoning in children is a global problem; it has peak incidence between one and five years. Nearly 70% of all recorded cases of poison ingestion in children occur in this age group. Children of this age have a strong urge to put things into their mouth both for identification and oral gratification, although many of the substances they take are unpleasant both in appearance and in taste. Incidence is more common among boys as they are more aggressive and exploratry by nature. Pattern of childhood poisoning varies considerably between different communities and between rural and urban areas due to exposures to different types of potential poisons.

Risk factors for increased incidence

I Poor Socio-economic circumstances

- In small houses there is little facility; hence, safe keeping of harmful substances is less easy.
- Supervision may be less strict as the mother is often too occupied with routine household work.
- Parents are likely to be less knowledgeable about the harmful effects.
- In poor families hunger may be a stimulus to ingestion of harmful substances.

II Children of psycho-socially disturbed families are at greater risk.

III In certain situations like families of doctors and people dealing with metals such as gold, silver, lead (where acids and alkalis are freely used) the incidence is likely to be more. Poisonous substances can be classified into

a those occurring from domestic products.

b those resulting from medicinal drugs.

Nearly one-third to one-half of accidental poisoning in childhood is due to ingestion of substances which are used in day to day household work. The commonly ingested domestic products can be —

- non poisonous
- Potentially poisonous
- Poisonous

Non-Poisonous substances

Many cases of accidental ingestion involve a wide range of products such as pencils, water colour paints, chalk, ink, wax, gels, toys, crayons and a variety of cosmetics and toiletries. All these cause minor upsets like vomiting and diarrhoea. They do not require any specific treatment. But, this opportunity should be used to advise the parents about storage and use of all household products and drugs.

Potentially poisonous susbstances

Substances such as detergents, soaps and washing powders cause mild vomiting and loose motions, whereas bleaches and disinfectants especially the ones containing phenol and cresol can cause harmful corrosive effects on the mouth and oesophagus requiring immediate medical attention.

The batteries (disc and button) constitute a potential source of acute heavy metal poisoning. Those containing silver salts are nontoxic but the ones containing alkali, mercury or cadmium can be quite dangerous.

Poisonous susbstances

Substances which come under this group are insecticides, most of which contain organo-phosphorus compounds; camphorated oil, corrosives

and petroleum products and some of the other compounds, the commonest being kerosene. Camphor, naphthalene (moth balls) and rarely corrosives like acids and alkalies can cause poisoning.

Kerosene being commonly used both for lighting and heating is responsible for a significant proportion of poisoning seen in our population. Usually the amount ingested is small because, by then, the child starts to vomit and parents by its smell rush the child to the hospital. Apart from minor symptoms such as vomiting, a few cases may end up with complications such as pneumonia. They respond very well to supportive treatment and antibiotics, if indicated.

Children coming with *moth ball (naphthalene)* ingestion are also common. Moth balls are used to protect clothing during winter. These chemicals are absorbed by mouth, by skin and by inhalation. The toxic effects, whichever way it is absorbed, are nausea, vomiting, lethargy, abdominal pain, convulsions, anaemia, jaundice and shock. The most important advice to parents is not to use napthalene for storing babies' diapers and blankets, as toxicity by skin absorption has been well known in small babies. The babies that we have seen had all ingested small quantities and no fatalities have occurred.

Camphor toxicity is another childhood poisoning that we come across sometimes. This is used as an antiseptic, rubifaciant, in cold remedies and as a topical analgesic. One gram of camphor ingestion is quite toxic. Absorption occurs by oral ingestion, inhalation and through skin. Toxicity causes gastro-intestinal symptoms like nausea and vomiting; central nervous system symptoms such as hyperactivity, headache, agitation, restlessness and convulsions in severe cases. Treatment is mainly by removal of poison and symptomatic treatment.

Most of the *insecticides* contain organo-phosphorus compounds, usually not common in childhood poisoning but, seen in adolescents, and adults used in intentional poisoning. When ingested in large quantities, they can cause altered sensorium, convulsions, and muscular twitching. *Immediate hospitalisation is mandatory* for removal of poison, supportive care and specific antidotes — atropine, pralidoxime.

Poisoning with medicinal drugs

The drugs which are commonly used and kept at home are analgesics such as aspirin (salicylates), paracetamol, anticonvulsants like phenobarbitone, iron tablets (ferrous salts), and respiratory drugs such as salbutamol and theophyline. All these can cause fatal outcome, but fortunately we do not come across severe poisoning with any of the above mentioned drugs.

Iron poisoning

In the past two years, we have had four cases of accidental ingestion of iron tablets of large quantities, out of which three children succumbed to death because of severe hapatotoxicity and bleeding. Usually the symptoms appear in about 30 minutes to two hours in the form of vomiting, blood in the stools, abdominal pain and drowsiness; severe hepatic enlargement, convulsions, shock, and coma may appear 24 to 48 hours later. Treatment consists of removal of the poison, administration of deferoxamine — a specific antidote, and symptomatic treatment which includes blood transfusion. If the patient is seen more than three hours after ingestion of a large quantity, the outcome is poor because enough absorption to cause toxicity would have occurred.

Salicylate Poisoning (Aspirin)

Yogesh, four year old son of a nurse, consumed a large number (exact quantity unknown) of aspirin tablets from a bottle kept in the unlocked cupboard. The mother noticed the child with abnormal behaviour, the body felt cold. The child began to vomit. The mother rushed the child to the hospital. The body temperature was subnormal. With proper management, Yogesh recovered.

We have seen children wherein excess dose (more than 150 mg/kg body wt) is administered therapeutically. It is one of the reasons for fatal poisoning in childhood. Toxicity results in deep rapid breathing (hyperventilation) due to central stimulation, thirst, vomiting, profuse sweating, and in severe cases confused state, convulsions, circulatory collapse. Treatment includes removal of the poison by stomach wash, and treatment of shock, acidosis (a condition of decreased alkalinity of the blood and tissues) and dehydration.

Paracetamol

This is being used more often than salicylates as an analgesic and antipyretic; consequently it is easily available at home and most frequently ingested by children.

Fortunately we have not come across children with paracetamol poisoning. The major toxic effect of paracetamol is on liver which is noticeable after two to three days; patient usually feels well between 24 to 48 hours.

N-acetylic is a specific antidote

Children have been given therapeutically very high doses of respiratory drugs such as salbutamol, theophylline or terbutaline; this is of common occurrence in our set up. Usually these cause excessive crying, agitation, tremors, tachycardia, cardiac rhythm disturbances and various metabolic consequences. Treatment is mainly symptomatic and supportive.

General Management

The major considerations are —

1 Removal and inactivation of the poison where possible.

2 Enhanced excretion of poison,

3 Provision of supportive care.

A quick history and physical examination should be undertaken to identify the poison. The next aim is to remove the poison by vomiting (spontaneous or forced) or by stomach wash. Usually vomiting occurs spontaneously in many childhood ingestions or one can induce vomiting by administering either ipecac syrup or giving a glass or two of water and stroking the back of throat. Forceful vomiting is not recommended when there is altered consciousness, strong acid or alkali ingestion, kerosene ingestion and in infants less than six months of age.

Syrup of ipecac is the most frequently used agent to induce vomiting, given in a dose of 10 ml for children more than six months of age and 30 ml for children older than one year. Administration of this agent is encouraged at home because the time interval from poison ingestion to treatment is decreased. The adverse effects are diarrhoea, drowsiness and irritability in a majority of children.

Stomach wash is another mode of removing poison which is not employed when a patient is unable to protect the airway, is actively convulsing and has an altered level of consciousness. It also alters the toxin bio-availability. Stomach wash is contra-indicated in kerosene and caustic ingestion and comatose (affected with coma) patient.

Administering activated charcoal helps in absorbing the toxin which prevents absorption. It is given in a dose of one to two g/kg body weight. Activated charcoal is contra-indicated in mineral acid, alkali, boric acid, cyanide, iron and lithium poisoning.

Enhanced excretion

Most cases do well with conservative therapy and only a small percentage of serious poisoning require methods of enhancing excretion by usage of diuretics.

Dialysis

Peritoneal dialysis, hemodialysis and exchange transfusion, though not part of the usual emergency treatment, are reserved for the most severe cases.

Supportive treatment

This is an important part of the management which ensures adequate air way for exchange of gases, prevention of pneumonia, maintenance of fluid and electrolyte balance, antibiotic treatment of infections, correction of shock, control of convulsions by anticonvulsant drugs and nursing care for patients in coma.

There are a few specific antidotes available for certain poisonings and are to be used as warranted. The so-called universal antidote, a mixture of charcoal, magnesium hydroxide and tannic acid, is ineffective and should not be used.

Prevention of childhood poisoning

No course of therapy no matter how trivial the ingestion, is complete without a discussion about why the poisoning has occurred and a review of methods to ensure that the incident will not be repeated.

As a precautionary measure, one should instruct poison prevention and poison proofing homes to parents during check-ups of their babies.

One should also educate parents regarding provision of proper storage of medicines and other

cosmetic products so that they are out of reach of children. Safe disposal of old medicines and products, labelling of medicines which are in use, returning of a medicine or a poisonous household product such as an insecticide to its proper place after use are other important steps. It is the responsibility of the parents to create a safe environment for the child.

Poison Checklist

Make certain your house is safe. When you can check off every question, your house is poison-proof.

Kitchen

Do all harmful products have child-resistant caps?

Are all potentially harmful products in their original containers? If not, you may be without important first-aid information on labels in the event of poisoning. And if a poison is stored in a used food container, someone may think it is food and swallow it.

Are all harmful products up high in locked cabinet, well away from food and out of reach of children.

Do all medicines have child-resistant closures?

Have you discarded all out-of-date prescriptions? As medicines age the chemicals in them change., making a once-safe medication a potentially dangerous poison.

Do you give medicines only to the persons for whom they're prescribed?

Are all medications in their original containers with the original labels? If not, mistakes are possible. (Did you know that some poisonous cockroach tablets look just like aspirin?)

— Parents

★ Children learn what they live

If a child lives with criticism, he learns to condemn.
If a child lives with hostility, he learns to fight.
If a child lives with ridicule, he learns to be shy.
If a child lives with shame, he learns to feel guilty.
If a child lives with tolerance, he learns to be patient.
If a child lives with encouragement, he learns confidence. If a child lives with praise, he learns to appreciate.
If a child lives with fairness, he learns justice.
If a child lives with security, he learns to have faith.
If a child lives with approval, he learns to like himself.

If a child lives with acceptance and friendship, he learns to find love in the world.

★ Encourage Play

"He is only playing," is still heard frequently.

Play is in fact an intensely absorbing experience, and more important to the child than work is to an adult.

Through play the child acquires control over the movements of his body, at first with easy tasks and then with more complex ones such as hopping on one foot, and eventually in playing complicated games, perhaps with his parents. As well as playing with his limbs, the child also plays with sounds, imitating sounds from his mother and others nearby. The chanting of nonsense rhymes and jingles gives him a sense of power over words. Play also makes it possible to develop social skills with adults and peers.

Accidents and abdominal injuries

Dr C S Rajan

Pretty three year old Sureka ran out of the house to join her father, Mr. Menon, who had started his scooter ready to go for the days' shopping. Mr.Menon put Sureka on the floor of the scooter in front of his seat and, waving goodbye to his wife, set off. While little Sureka chattered, Mr.Menon, a small scale industrialist, was lost in thought about the impending new contract he had to sign later in the day. As they approached the market road, Mr.Menon found himself behind a bullock cart loaded with vegetables. As he tried to overtake this bullock cart, a speeding lorry came at him from the opposite direction. To avoid the path of the oncoming lorry, Mr.Menon swerved and crashed into the wheel of the bullock cart. Both he and Sureka were thrown off, luckily in the direction away from the path of the lorry. Mr.Menon found his daughter lying still, bleeding profusely from an ugly gash on her forehead. Her cheeks were pale but the chest moved reassuringly with breathing. Fearing serious head injury, he lifted his child in his arms, got into an autorikshaw and rushed to the emergency section of the local mission hospital nearby. The doctor on duty examined the child and found no evidence of any serious head injury. He told Mr.Menon not to worry and asked him to wait outside while he sutured the wound on Sureka's forehead.

While the doctor was suturing the wound, a nurse came running in to say that the child's father had fainted on the bench outside. Mr.Menon was found to be pale, with hypotension and a thready pulse. Examination of his abdomen revealed a dark bruise on the left upper quadrant. Suspecting haemorrhage into the abdomen, resuscitation measures were started. A senior surgeon confirmed the clinical diagnosis and ordered an immediate operation. Within one hour of reaching the hospital, Mr.Menon was operated. The surgeon encountered over two litres of blood in the abdominal cavity. The bleeding was traced to a ruptured spleen. A splenectomy was done and all bleeding stopped. Both Mr.Menon and Sureka made an uneventful quick recovery from their wounds.

Accidents have been described as an occurrence of a sequence of events which usually produce unintended injury, death or property damage. Accidents are an epidemic and rank within the first four chief causes of death in almost all parts of the world.

Accidents, be they traffic, industrial or domestic, can involve the abdomen of the victim, contributing to significant morbidity and in severe cases, mortality too. Trauma to the abdomen may either be blunt or penetrating. This trauma may cause injury to the walls of the abdomen, or the viscera inside. Liver, spleen pancreas or kidneys may be injured resulting in bleeding. The hollow organs like stomach and intestines may be ruptured resulting in leak of intestinal contents into the peritoneal cavity giving rise to peritonitis.

Sixteen year old Sumen was up on the guava tree in her father's orchard plucking guavas. Her foot slipped on a branch and the only other twig supporting her weight snapped and she fell 10 feet to the ground, on her haunches. She felt a sharp pain in her lower abdomen, and was taken to the hospital. The surgeon on duty found all signs of peritonitis but with no external injury evident. However, as he prepared to do a digital rectal examination, he found a half inch laceration alongside the anus. He probed the wound, and found it extending quite deep into the pelvis. An X ray of the abdomen in the erect position revealed free gas under the domes of the diaphragm,

a sign of hollow viscus perforation. An immediate laparotomy showed a six inch wooden stick, 1/2 in diameter, lying in the abdomen, perforating the rectum and the small intestines. Apparently, Suman had fallen on this erect stick in th ground beneath the guava tree. It had entered her abdomen through the perineum and injured her intestines. Timely surgical intervention averted major complications.

Diagnosis:

All medical personnel are bound to meet cases involved in accidents with resultant trauma to the abdomen. While all cases of penetrating injury are referred directly to the surgeon, blunt abdominal trauma needs proper clinical assessment to arrive at correct diagnosis. Guidelines for the immediate recognition and prompt referral of cases to the surgical unit:

1 Obtain significant details of the accident; even small facts may give vital clues to the nature of injury and possible damage to the abdominal organs.

2 A quick survey to rule out injuries to the head and chest; these may cause immediate mortality, and are often missed when the patient's prime complaint is abdominal.

3 Ask for any abdominal pain. If present, its location radiation and reference (for example, the left shoulder) give important clues as to the possible intra-abdominal injury.

4 Find out about vomiting, passing of urine and stool after the incident and any evidence of blood in any of these discharges.

5 Do a quick general assessment of the patient, for pallor (indicating blood loss), and the pulse, blood pressure, respiratory rate.

6 Expose and survey the abdomen. Look specifically for bruise marks on the abdominal wall and back. These may indicate sites of internal organ injury. Observe the movement of the abdominal wall with each respiration. Restricted movements are sinister. Abnormal fullness, localised or generalised, to be noted.

7 Palpate the abdomen — tenderness alone may be a result of abdominal wall contusion, but if accompanied by guarding and rigidity, are a definite indication of peritoneal injury and irritation by blood and/or leaking intestinal content.

8 Percuss the abdomen — Dullness in the flanks that shifts, may indicate collection of blood. Absence of the normal dullness over the liver may indicate free gas in the peritoneal cavity from a perforated hollow viscus.

9 Ausculate the abdomen — a 'silent' abdomen is almost the result of significant trauma.

10 Examination of the external genitalia, perineum and a digital evaluation of the anus and rectum go a long way in helping avoid injuries being missed.

11 Turn the patient to the side and examine the spine. Many injuries of the spine produce reflex abdominal symptoms suggesting abdominal trauma.

Having now established a clinical diagnosis of abdominal trauma, the patient is referred to the general surgeon for his further assessment and management. The general surgeon besides going through the steps of the above clinical diagnosis uses certain tests and invasive procedures to help confirm the clinical suspicion. These are —

1. Radiology:

The use of erect and supine radiographs give vital information about abdominal injuries. Presence of free gas under the diaphragm denotes hollow viscus perforation, while loss of outline, haziness and dilated loops suggest bleeding from solid organ injury. In case of suspected kidney injury, an emergency intravenous urogram is done, while for ruptures of the urinary bladder or urethra, a cystourethrogram may be indicated.

2. The Peritoneal Tap:

Using a 10 ml syringe and 20 G needle, with aseptic precautions, the surgeon inserts the needle into the abdomen (on the flanks) and aspirates. Presence of free flowing blood into the syringe confirms internal bleeding, while aspiration of bile stained or faecal stained fluid confirms hollow viscus perforation.

3. Imaging Techniques:

The use of Ultrasound and the computerized Axial Tomography helps ascertain in greater detail the exact nature and extent of trauma.

MANAGEMENT

General measures include insertion of intravenous access, obtaining patient's blood for basic studies as well as to group an Rh type and reserving blood in the blood banks for any need of the patient. Nasogastric aspiration, intravenous fluids and urethral catherization are necessary. Record vital signs and watch for abdominal signs like distension.

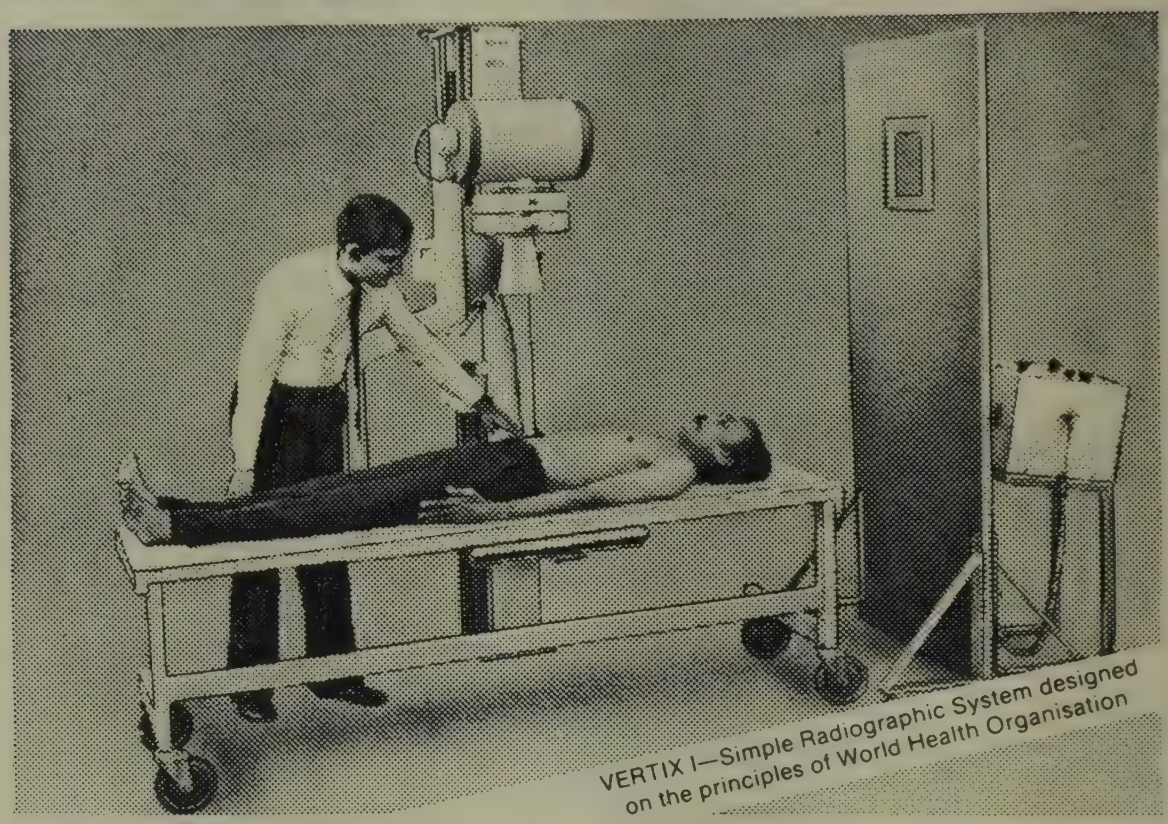
Specific measures:

For all cases of intra-abdominal bleeding and hollow viscus perforation, an immediate midline laparotomy is performed. The bleeding source is either ligated and sutured (example, liver injury) or excised (example, splenectomy in splenic injury). The sites of bowel perforation are closed, or the segment resected. Retroperitoneal haematomas are usually not touched. Kidney, pancreatic and duodenal injuries are treated conservatively. Ruptures of the urinary bladder and urethra need repair with urinary drainage.

Remember, children take threats seriously and subconsciously act out the threat by passing the threat to the immediate youngster around

SIEMENS

Siemens offer a wide range of quality X-ray Products to meet all Radiological Applications



VERTIX I—Simple Radiographic System designed on the principles of World Health Organisation

X-ray Generators:

- UNIDOR 20 portable
- PLEODOR 3E 60 mA
- NANOPHOS 100 mA
- ERGOPHOS M 160 mA
- PLEOPHOS D 300 mA
- HELIOPHOS D 500 mA
- POLYMAT 50 I 800 mA

Basic Radiographic Unit:

VERTIX I (specially for Rural and Primary Health Centres)

Diagnostic Tables:

- POLYSKOP Manual Tilt
- Bucky Table Horizontal
- KLINOSKOP and KLINOGRAPH E Motor Driven Table with Semi and Automatic Spotfilm device.

For Physiotherapy:

ULTRATHERM.

For Surgery: RADIOTOM.

For details, please write to:

Siemens Ltd.
Medical Engineering Division
130, Ganpat Jadhav Marg
Bombay 400 018

Regional Offices: Bombay, Calcutta, Delhi, Madras
Branches: Ahmedabad, Bangalore, Hyderabad

HTA 2493

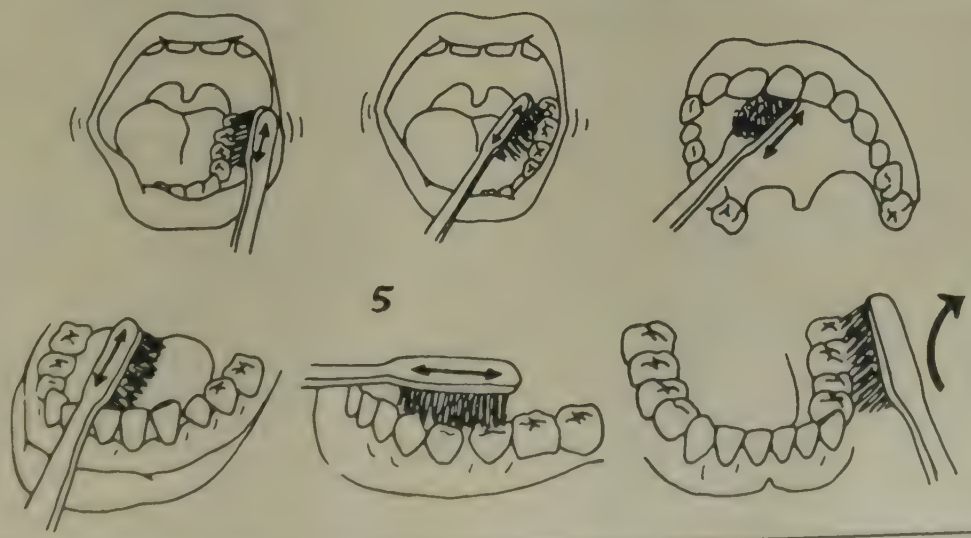
Tooth paste, tooth brush and you

What is the most impossible thing to do in the world? Some wag has said, "it is sending back the tooth paste which has come out of the tube". How one wishes it were true! Many times a dentist is asked which tooth paste should one choose. The subject needs an elaborate explanation. It's time all assumptions and false claims made by the advertisements are cleared.

A tooth paste normally contains, apart from other ingredients some aromatic and strong tasting substances like menthol and peppermint. The moment one puts tooth paste in the mouth there is strong salivation and one rushes to the sink to spit it out. The expensive and highly fancied tooth paste is thrown out in a minute and the terminal part of the brushing is done with one's own sweet saliva! A tooth paste at best is like a soap. It is a matter of personal preference, which brand of soap one likes to use. Just as no soap can claim to treat any skin problems, no tooth paste can boast of effecting a magical cure. When a tooth paste and a tooth brush is used, it is actually the scrubbing effect of a tooth brush on teeth that does more to clean it than the tooth paste. At the most, the paste can complement the brush.

Tooth Brush:

Compared to the tooth paste, the media has been kind about the tooth brush. Not as much advertising takes place for the brush as for the paste. In the oral hygiene ritual the tooth brush takes a pivotal role. The mechanical scrubbing of brush on tooth surfaces



and gentle stimulation of the gums is the most vital part in oral hygiene. USING ONLY BRUSH IS ALMOST AS EFFECTIVE AS BRUSHING WITH TOOTH PASTE. Since one is accustomed and conditioned about tooth paste, it looks preposterous to use only a brush, even though it is adequate.

There are many considerations in selection of a tooth brush viz.

★ The consistency of the brush i.e hard, medium, soft etc.

★ The size of the brush head

★ Angulation of the handle

★ The number of tufts, the number of rows

★ The nature of the bristle ends

Your dentist should be able to advise you about the type of brush which is suitable for you.

The brush should be small enough to reach all nooks and corners of all teeth but not too small-so as to make it a frustrating experience. Try a child brush and see how dissatisfied you feel!

Ordinary healthy gums can tolerate hard to medium brushes. Bleeding and spongy gums, however, require a soft brush. The tip of the bristles is supposed to be rounded and everybody is making this an issue in advertisements. It does not really matter and a bristle end will in no time become smooth and blunt with use.

There are many exotic angulated brushes available in the market. You can select any angulation (or no angulation) according to your convenience.

How often should one change a tooth brush?

Again it depends on one's use or rather the thoroughness of it's use. People who chew their brushes absentmindedly and mutilate them overnight, will need to change them very often. A general rule of the thumb is to change the brush whenever it starts fraying and loses the original shape. Persisting with a deformed brush is negating the very objective of brushing. After brushing, the brush must be washed well and hung on to dry. Brushes used by different people should not be put in the same glass or container for obvious sanitary and hygienic reasons.

How often should one brush?

It is not the number of times but the thoroughness with which you brush which determines the ultimate effectiveness. There is a basic difference in brushing times between the Indian and Western world. Based on a religious and social custom, Indian tradition demands that one's day starts with cleaning the teeth. Most Indians do not brush at night before retiring to bed. Most of the day's collection of Dental plaque and food residue is allowed unlimited freedom in the night-to cause damage uninterrupted by the protective effect of saliva, tongue etc. If these deposits are removed before retiring to bed, it is more useful. There is an acute need to change people's brushing habits so that a before-going-to-bed brushing becomes a ritual in every home!

Sexual abuse in children

Child sexual abuse is a problem which has not received sufficient attention in our country. Two articles have appeared recently in the Journal of Applied Medicine, Vol 15 number 8, August 1989. The first one is on "Description and recording of physical signs in suspected child sexual abuse" by Dr. H. Steiner, University of Neweastle-upon-Tyne and M. Taylor, South Shields General Hospital, U.K. It highlights the need of an accurate and standarised record of the findings and an accurate interpretation of abnormal physical signs. The second article is on "Incest in childhood and adolescence: long-term effects and therapy" by Dr. D.J. West, University of Cambridge, U.K. It calls for discrimination in the assessment and management and in balancing the interest of victims against the demands of justice. Involvement and abuse of children in sexual activity in our country is far greater than is thought to be and it is necessary to focus attention on this problems as it leads to physical trauma and, more importantly, grossly disturbed behaviour.

We have a problem

Jane Marks

"Meena was just eleven when her diabetes showed up, but she accepted it like an adult", said her mother, 36. "She gave up all the sweets and junk food she loved, and she exercised diligently. And though she'd always been terrified of injections, she now took her morning insulin shots like a real pro.

"The doctor says nobody ever gets rid of diabetes, but I'll bet I can", Meena told me after a checkup. Well, she had conquered her nail-biting habit, and maybe she had willed away that funny little wart on her knee, but didn't she understand that this was different?

The doctor had told us that Meena's Type I, or insulin-dependent, diabetes was serious and chronic. Meena's body was unable to produce insulin, which is a hormone we all need to process our food and maintain a normal blood-sugar level. Meena would need to take insulin shots for the rest of her life.

"The problem", he went on, "was not taking the shots, it was having to constantly adjust and readjust the dosage, as too much or too little could cause big problems. That's why Meena would have to be extra careful with her diet and exercise, and why she had to draw a drop of her blood several times a day to check her sugar level.

The doctor said that Type I diabetes requires vigilant care and monitoring. By the time she was thirteen, Meena needed more frequent shots of insulin, and the whole task of keeping her blood-sugar and insulin levels in balance was getting harder — for both of us.

"It's just not fair," she said, cranky and despondent. "I've tried so hard to be good and I still have it, so what's the point of going through all this?"

"There's lots of point", I assured her. She couldn't get rid of her disease, but she could lead a happy, normal life if she just kept her food intake, her energy expenditure, and her insulin level in balance.

"And it was a daily balancing act! Too much food, too little exercise, a case of the flu, or too little insulin would make her hyperglycemic. She would feel nauseated and maybe vomit. And if left untreated, her condition could lead to a coma — and even death.

"The opposite problem — hypoglycemia — is also a complication of diabetes that comes from too little food, too much insulin, or too much exercise. And it comes on more acutely. The symptoms of this include sweating, trembling, anxiety, confusion, and blacking out.

"And the really scary part, we were learning, was how many things could affect the delicate balance. Like Meena's worrying about a test at school or

staying up too late or having a little sore throat. All of those had given her symptoms.

"And now, with her body growing and changing so rapidly, her vulnerability was higher than ever. "Adolescent growth spurts and hormone changes will make her diabetes harder to control", The doctor cautioned us.

"But now, instead of understanding that all this meant we had to be extra careful, Meena seemed more and more casual-and sloppy-about her health. Often, I found that if I didn't remind her to test her blood, she would forget-or not bother. And while I tried to make sure that she ate the right things in the right amounts at the right times, I'd find all these hidden bags of potato chips and other evidence of cheating, and I'd feel so helpless!

"Meena was at that age of terrible insecurity — dressing like all her friends and afraid of being one tiny bit different — she forbade me to tell anyone about her disease.

"I'd say, "But, Meena, if you're going to dinner at your friend's, I'll have to tell her mom so she can give you a snack if supper's going to be late". But Meena would command me to stop worrying.

"Well, I wanted to stop worrying ! I wanted Meena to take the responsibility herself. But she wasn't doing it! Like that night she went to her friend's:" Meena said nothing and waited politely for dinner. At seven-thirty, her friend's mother noticed Meena drenched with sweat, confused, and shaking — and immediately brought her home.

"All I needed was some orange juice and I would have been fine in ten minutes," Meena said, crying tears of embarrassment and anger.

"But this will happen again and again if you won't let me tell people what you need or if you won't tell them yourself", I pointed out. The next day was cold and drizzling. "I'll go for that run with you", I offered. But she said, "You go", and went into her room and slammed her door.

"I hated Meena making her illness a power struggle when we needed to work together. I thought that if she didn't want to listen to me, then perhaps she would "hear" the facts and warnings better from strangers.

But from the child's point of view, she is constantly irritated by the concern shown by her parents and would like to be left alone. Parents all think they're helping! You need to tell them — lovingly but firmly — when they've embarrassed you. And explain that you need to be able to take care of things on your own, says a counsellor.

"Will they accept that?" a girl asks.

"Maybe not at first", he says. But they'll get the message a lot faster if you make it your business to demonstrate how responsible you are. "After all", he went on, "they're hovering because they love you not because they hate you. If they feel that you are safe, they may be very glad and relieved to get off your backs".

Most children.. hate their friends to know. But counsellors say that telling friends might help. Instead of being horrified about shots and blood tests, they may respect them for being able to cope.

"That's why sometimes I just feel, I can't be perfect, so why even bother?" says one child.

"None of us is perfect", That's why it's so important to do three things: first, learn as much as you can about your disease. Learn how the disease affects you so that you can recognize and promptly treat even your subtlest symptoms. Frequent testing is important, and keeping a dairy can help you learn whether it's anger, for example, or boredom or loneliness that triggers your "forgetting" insulin or going on food binges", says the counsellor.

"The second thing, was always to be prepared for the unexpected. Always having an emergency snack in your pocket, and letting your teachers know that you are diabetic, so they can help if necessary.

"And the third thing," "is to keep expectations realistic on both sides: to be tolerant when you parents are a little protective and also to be willing to say to your mom or dad, "Look, I am not perfect. I might cheat on my diet and forget my shot sometimes, but I'm still coping well with a lot of responsibility. And the more you can focus on that and notice when I haven't had trouble, the better we'll all feel".

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

Prevention of dental caries

Dr C D Reddy M DS Dr S Hamid Abu Talib BDS

The primary lesion in dental caries BEGINS at the tooth surface and, if not arrested or removed, progresses inward, ultimately involving the pulp. Initial caries lesions occur most frequently on those tooth surfaces that favour the accumulation of food stuffs and oral micro-organisms. It is now known that one of the earliest changes detectable at the research level is a loss of mineral from the subsurface enamel. In the majority of instances, the first clinical change that is observed, in enamel dental caries is a whitening of the surface at the point of attack. Although this whitening may escape notice when the tooth is moist, it is easily detectable when the tooth surface is dried carefully and examined. Subsequently, the chalky appearing area softens further until a cavity is formed and is penetrable with a dental explorer.

There is general agreement that there are three major factors which should be considered if we are to understand the carions process. These are (1) fermentable carbohydrate food stuffs, (2) the oral microbial enzymes and (3) the physical and chemical composition of the tooth surface. The fermentable carbohydrates and the microbial enzymes may be considered as attack forces; the tooth surface as resistance force. Initiation of dental caries depends on the presence of a cariogenic oral microflora, a favourable substrate and a susceptible tooth surface.

The researchers have put forward various theories as regards the aetiology (and pathogenesis of dental caries) e.g. fermentable carbohydrate theory and proteolytic theory. The former is more acceptable universally than the latter.

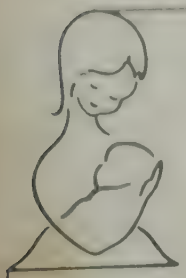
The epidemiology of dental caries:

Throughout his evolutionary advancement, man has been subjected to a constant changing environment. Some of these alternatives have proved beneficial, others detrimental to his well being. Among those environmental problems with which man has been unable to cope completely is an increased suceptibility to dental caries. There are billions of carions teeth in the world which need being filled, that cannot be cared for professionally for various reasons, such as economy, prevalence of the disease and a lack of complete preventive and corrective measures. In view of this situation, dental caries assumes the enormity of a major international problem. In developing countries and under-developed countries, the paucity of necessary funds, make the situation more alarming and hence the masses suffer from this disease more. The occurrence of dental caries has become universal, affecting all ages and all races, from all geographic areas of the world. In view of this epidencological factor, it becomes much more important to think about the prevention of dental caries than concentrating on filling the cavities. Now-a-days the incidence of dental caries in our child population is increasing at a very high rate, and it is very essential to control it through preventive measures. Unless and until we take it as a national programme, we are not going to achieve the desired results.

Prevention of dental caries through preventive dentistry:

Preventive dentistry is a positive approach to the practice of dentistry. It attempts to prevent diseases entirely and yet whenever they occur it involves itself in the correction and prevention of further complications.

Prevention encompasses all the procedure that is essential to prevent and arrest the incidence of dental caries. The prevention of dental caries in children in



particular and adults in general should be carried out at three levels.

1. Public Health measures to reduce the incidence of dental caries in a community.
2. Measures that can be undertaken by the dental surgeon at the chairside for individual children and adults.
3. Practical measures that the individual, child and his parents can carry out at home for themselves.

Caries prevention is based on:

— Increasing the resistance of the host through balanced diet, community drinking water with optimum fluoridition and topical fluoride application & F.S.

— Lowering the number of microorganisms in contact with the tooth (plaque control) by proper tooth-brushing, rinsing and dental-flossing;

— Modifying the substrate by selecting non-cariogenic food-stuffs e.g. evidence of fermentable carbohydrates;

— Reducing the period of time available for cariogenic activity by limiting the frequency of intake.

I. Community or Public Health measures:

It has been repeatedly stressed during research that primary prevention, i.e. protecting against the disease, is far superior to the hitherto practised treatment by drilling and filling. Public health measures to reduce the incidence of dental caries in a community is the responsibility of the government & quasi government organisations like municipalities. Today's alarming incidence of dental caries is going to be tomorrow's national disaster. Organisations like Public Health Department, Municipalities have to create an awareness in the masses about dental caries, that it is a destructive disease of the tooth and the damage caused by it is permanent. This awareness can be created through mass medias like T.V., Films, Radio Talks, Exhibitions and by distributing relevant dental health literature and school Dental Health Programmes. One of the primary duties of the local bodies or municipalities should be to ascertain whether the community drinking water contains the required quantity of fluoride or not. The effect of Fluoridated drinking water on the incidence of dental caries is very well known. If the community drinking water contains IPPM (IPPM represents 1G of Fluoride to every 1000 litres of water), which is called the optimum Fluoride content, then the incidence of dental caries is reduced by about 50-70%. If the fluoride content of community drinking water is more than the optimum level of I P P M, then there is a danger of Fluorosis which manifests itself in the teeth as mottling of the enamel and in extreme cases as yellowish brown discolouration.

It is imperative on the part of health authorities to keep a close watch on the fluoride content in the community water supply or domestic water points and evolve methods of defluoridation, particularly in the districts where flourosis is rampant.

There are other methods of supplementing flouride in flouride deficient areas like salt flouridation, milk fluoridation for school children and flouride tablets.

II. Measures that the dental surgeon can take at the chair side:

1) Plaque control:

Dental health can only be achieved if the patient is willing and able to practice a correct programme of plaque control. The bare minimum requirements for plaque control are correct technique of tooth-brushing, rinsing mouth after every meal and dental flossing. These techniques need to be demonstrated to the patient by his dentist. Parent counselling and instructions for home care are of paramount importance.

2) Topical application of Fluorides:

Before embarking on the topical application of Fluorides, it is a must for the dental Surgeon to do oral prophylaxis (scaling) and polishing of teeth. When the surface of the teeth is elevated by plaque or calculus, the effectiveness of fluorides is very much reduced. Most commonly used topical fluoride solutions for the prevention of dental caries are: (1) Sodium Fluoride Sol. (2) Stannon Fluoride Sol (3) Acidulated phosphate fluoride (APF)SOL or gel.

3) Fissure-sealants:

The present day fissure sealants attempt to prevent caries in those areas where Fluoride, either systemic or topical is less effective. Various material like copper, cement, silver nitrate has been advocated for placing in the pits and fissures. They were tried but with less encouraging results. An ideal sealant should be all round tooth surface and fissures. This type of sealant prevents bacterial invasion and subsequent caries function. The most recently developed & more accepted fissure sealants are:

a) Polyurethanes
b) Bisphenol + Glycedyl Methacrylate + Methylmethacrylate Monomer + Catalyst = Un Light
c) Edoxylate 9070
d) Elmex protector
e) Duraphat

All the above mentioned fissure sealants offer various advantages because of convenience in application or prolonged protective action. However the basic concept of application of the fissure sealants is to seal the pits and fissures and to protect the inaccessible tooth surfaces from cariogenic activity.

III. Practical measures you can take at home:

The prevention of caries can best be achieved for the children by their parents. If the parents are aware of the knowledge of proper oral hygiene, then they can teach their children better about home-care of the teeth. Moreover, the children tend to copy their parents in their day-to-day life. Hence parents can become best Dental-Health-Educators for their kids. Broadly home-care can be discussed under two headings, viz. a) Nutrition b) Oral hygiene

a) Nutrition:

Every child needs balanced nutrition for his overall growth and development. The growth and development of teeth also require adequate nutrients. The parents should take note that children need raw vegetables and sufficient roughage in their diet so as to have the natural cleansing action of tooth surfaces. They should also see to it that children do not consume more sweets and candies which are cariogeric in nature.

Snacks between meals should be cut down. In case they consume some sugars and candies between meals, then it is advisable to ask children to brush their teeth immediately after such snacks.

b) Oral Hygiene:

It is the duty of the parents to supervise the oral hygiene methods carried out by their children. The correct tooth-brushing technique needs to be demonstrated and taught to the children by their parents. the habit of rinsing the mouth after every meal and snack goes a long way in arresting the caries activity. It is more admissible to ask children to use Flouride tooth pastes and Fluoride mouth washes. It arrests dental caries and srengthens tooth surface. Last but not the least is the habit of dental flossing which is very essential, to eliminate inter-proximal dental caries. Nowadays it is a common sight in developed countries to see children dental flossing every now and then.

Getting Hold On Babies

The ways men and women hold babies satisfy different needs of the infants, according to Jerrold Lee Shapiro, Ph.D., associate professor of counseling psychology at Santa Clara University in California. While doing research for his book, When Men Are Pregnent: Needs And Concerns of Expectant Fathers (Impact Publishers). Dr. Shapiro filmed men and women's interactions with infants.

He found that a woman tends to wrap herself around a baby, with the baby's face towards her chest. This, he believes, provides the baby with warmth and security and lessen the baby's fear of abandonment. A man, however, tends to hold a baby facing away from him, giving the baby a sense of freedom and lessening his fear of suffocation.

Temper tantrums

Dr. Shoba Srinath

Mohit, a three year-old insisted on being carried by his mother, who was otherwise occupied. Since she did not do so immediately and told him to wait he became upset, started crying, rolled on the floor, thrashed his feet and cried with great intensity. His mother ignored him and finished her work and only then did she go with his favourite toy and though he was still whimpering, invited him in a very pleasant way to play, which he did.

This is just one example of a tantrum. An occasional tantrum is of no significance. Tantrums are normal between the ages of one to six years and reach their peak between one to three years of age. Frequently occurring temper tantrums are very often due to the fact that the parents have not learnt the knack of handling the child tactfully. Occasionally it may happen that the child is physically ill, very tired or has a difficult temperament.

The following are some of the guidelines parents can use in handling their children:

Child needs to play and explore: Ram is a 3½ year-old boy, who is not allowed to play out of doors freely and since the house has a number of things which can be destroyed by a young child of his age, he is constantly reminded to be careful, and not be naughty.

Now, this child cannot be expected to obey always without becoming frustrated over his inability to explore and move freely. This youngster is prone to develop far more tantrums.

Divert and distract attention before the start of a tantrum: This is a common and very effective method used by most parents. Sunita a four year-old, usually has a temper tantrum when asked to come for a bath. Her mother now takes her for a bath along with the small plastic doll which Sunita is allowed to bathe. This has remarkably decreased tantrums associated with a bath.

Unrealistic expectations: Shyam, a three-year-old, has eaten a small quantity of his lunch and says he wants no more. He is a healthy youngster developing normally. His mother now insists that he eat everything and force feeds him. The result is that he yells, cries, throws his plate and upsets the glass of water. His mother feels, that a boy of his age must eat much more.

Children are not hungry sometimes, so if Shyam does not want the rest of his food he should not be forced. The mother may be wrong in her judgement as to how much he needs. In any case even if the child eats a little less his health is not going to be seriously impaired.

Ignoring tantrum if the child's demands are unreasonable: Tantrums will gradually disappear if the parents do not give in to the demands no matter how unpleasant or uncomfortable the tantrum. Holding the child on the lap of the adult will prevent him banging his head. It is best for the parent not to yell, scold, or threaten when he waits for the tantrum to stop. When the screaming, yelling decreases and shows signs of stopping, the child can be distracted and played with. The idea is that the child, over repeated trials, learns that "even if I cry, my demands are not met, when I stop crying they will continue to be nice to me and 'like' me, yet not give in to my demands". It is possible that there may be a sharp increase of tantrums for a few days as the child is surprised at this new disciplinary measure and resists it. When a tantrum occurs in a public place like on a road or shop it is best to pick him up without showing how upset you are and go to a place with some privacy and then wait for it to stop.

Discuss this behaviour with the child if he is old enough: The parent can discuss with a six-year-old about his tantrum. Discuss what makes him angry, tell him how he can talk about his anger instead of behaving in this manner.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

Addictions — The bane of family life

M Leo Raj

Addiction! most people shy away from the very word! Yet, increasingly today we find that life ends up having us addicted to one or other crutch we pick up on this journey through life.

But what should really get responsible people down is the fact that addictions are taking hold of younger and younger people. In the US we have de — addiction centres geared to treat 6 year olds. And here in India it is not that much better!

Addiction takes many forms. The classics refer to a band of soldiers under Ulysses who lost themselves to the problems of the world by eating lotus stems which causes them to reach rapidly a state of bliss that was reinforced with fresh doses of the repast.

Young people today are alarmingly taking to chemical means of overcoming their problems of life, thus becoming the new lotus eaters.

While experimental abuse of drugs is common among youth everywhere (more than 50% in Urban Indian boys) if this occurs in the background of an unstable personality, a large number of stresses in the individual's life at that time or in the face of an emotional disturbance, a likelihood of drug dependence developing is considerably increased.

Not all drug addicts come from disrupted or unhappy families. Sometimes a drug problem in a healthy young child can cause the family to be totally disturbed.

One pattern of drug abuse frequently observed among youth is that initially legal drugs like tranquillisers are abused, then alcohol, smoking and progressing to hard drugs like Brown sugar, Heroin or Cocaine.

Peer pressure and persuation by friends is usually the main reason for addiction. At some point all kids are exposed to the dark world of illegal drugs and alcohol. Lets take them one at a time.

Smoking:

Young people start smoking out of a sense of curiosity, a desire to experiment and as an act of bravado.

Prompted by repeated exposure to advertising that entices the young to 'Relax' or 'Live Kingsize' or go real 'Macho', young people take to smoking. Once lady nicotine takes hold, often there's no way to stop.

The fact that three smokers in four die of tobacco-related diseases is, for a healthy young teenager, so remote a possibility that it makes absolutely no dent at all in his newly acquired "All male" feeling.

There is abundant and convincing evidence that tobacco smoking is associated with increased risk of developing many illnesses.

Take a quick look: shortened life span, lung cancer; cancer of the larynx (voice box), cancer of the mouth, cancer of the Oesophagus (food pipe) cancer of the Urinary bladder, cancer of the Pancreas increased risk of heart attacks, Bronchitis, Peptic Ulcers still births and low weight babies!

There will be a worldwide pandemic of tobacco-related diseases by the turn of the century unless major efforts are taken now to prevent it.

And Alcohol:

A WHO report says: Alcohol consumption is increasing and causing concern. Liver cirrhosis now ranks among the leading causes of death — and the most marked increase in consumption is in the developing countries and in the very young.

The 'bottle' however many social and commercial uses it may have, is the harbinger of great disasters and misery to most people.

The prolonged use of alchohol directly damages different parts of the nervous system and causes grave injury to the mind.

Alcohol results in:

a) Heart: unstable blood pressure; irregular pulse; enlarged heart;

b) pancreas: painful and inflamed

c) Liver: swelling; jaundice; cirrhosis;

d) Muscles: weakness loss of muscle tissue

e) Stomach: lining becomes inflamed; ulcers;

f) Nervous system: tingling and loss of sensation in hands and: feet

g) Brain: cell damage resulting in loss of memory; confussion, hallucinations;

h) Lungs — greater chance of infections including TB

i) Genitals: temporary impotence;

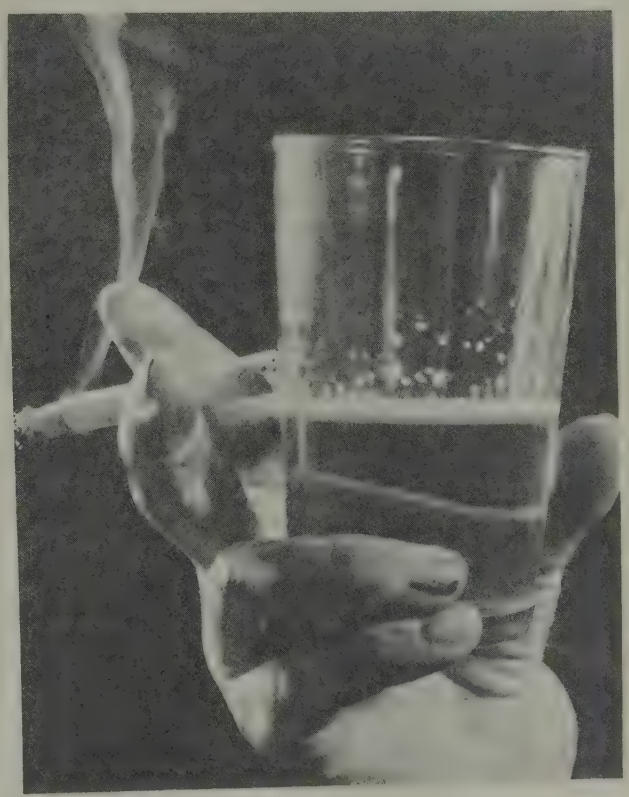
j) Skin: flushing, sweating, bruising

k) Blood: changes in Red Blood Cells.

Apart from this Alcohol creates devastating havoc in family life. Drains the family budget, creates serious disruption in family communication and leads to all kinds of traumatic experiences.

Drugs:

Drugs are the most dangerous of the lot. They work as stimulants, sedatives or hallucinogens. The euphoria is what is looked for and once hooked, they cannot break free. Do you know what happens when they are deprived of their next fix?



Soul-tortured even unto stealing, killing, the drug addict becomes a spent force ready to annihilate the world rather than let the lack of their fix annihilate them.

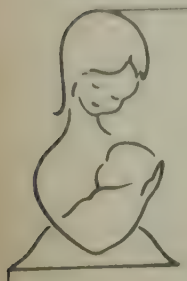
Drugs are big business and addiction is forced down the throats of the young, the unwary, the innocent!

Every parent should see this as a problem that he or she is likely to face in their own house, unless taken seriously.

In early 1980, no one had heard of smack in this country. Today, rough estimates tell us that there are 8,00,000 addicts in this country especially in Bombay and Delhi. The pathetic fact is that atleast half the number of drug addicts are children.

It is unrealistic to think your son or daughter can slide through childhood without running into drugs, cigarettes, alcohol, no matter where you live. These substances are available everywhere with the average age of first use now hovering around ten-eleven and continuing to drop.

How does one go about caring for children who are constantly exposed to the danger of addiction? How can parents help their children before the trouble begins? What should they do when they suspect something is amiss?



First of all, the whole family must understand that drinking, smoking and using drugs are subjects for discussion, not confrontation and that above all, they are not to be hidden. It is the inalienable right of parents to worry about their children. And parents have to set boundaries. You have to say: I'm the parent and you're the child, and these are the rules. But you must stress that you love, care for and understand their needs, their pressures, their problems.

Keep the channels of communication always open. Never 'shut off' or turn away from a young one with the plea that "you're too busy just now".

Communication about sensitive topics becomes difficult with a defensive teenager. Think about HOW you speak. Its foolish to scare the child. With teenagers, you can focus on a risk you both recognize. "Drinking and driving don't mix. Your reflexes aren't what they should be and you can fool yourself that you're driving better than you are". Death due to road accidents are very much a part of our children's experience.

One way to learn a lot more about your child is to ask questions: "Let me hear that whole story once more!" "How did that happen?" "What was it all about?"

Don't accuse; don't label; don't belittle your child's friends or classmates, remember they spent more time together right from kindergarden to whatever age they are now, hence hurting that relationship may work out negatively. Instead spend more time with your children. Become allies by saying, in effect; "I understand you want to do what your friends do. I'm concerned, what can I do?"

To be committed to talking to your child, you have to put down the newspaper, turn off the TV; put aside the cooking and take what is said, seriously.

Listen for what's not said when your child talks about a friend's trouble, maybe he's talking about his own.

Learn to be responsive to the unspoken clues that show a child wants to talk to you. A youngster who follows you around, who hovers near you all the time; who remains behind when everyone else has left the room; this one may be signalling she wants to say something. Open the communication door "Is there something on your mind? Do you want to talk about it?"

Talking alone may not solve the problem of addiction but it will set up a communication pattern that can make a difference if there is real trouble. You will also have developed a sense of trust between family members that will go a long way in helping children make decisions for themselves that make sense to you.

But whatever comes out in a conversation, most important is the fact that the child learns that talking is the pathway to finding the help needed to make things get better.

Above all, let your children know that whatever happens, you love them. That you care. And that you are always there for them. Anytime, any place!

★ Encourage new experiences

Language is the most needed experience of every child as he develops. Just as the body requires food for physical development and an appropriate balanced diet is essential for normal growth, so new experiences are needed for the mind. The two most vital ingredients in this diet in early childhood are play and language, and these are closely related. The fortunate child is the one who is bathed in words from his mother and other relatives.

A puff of poison

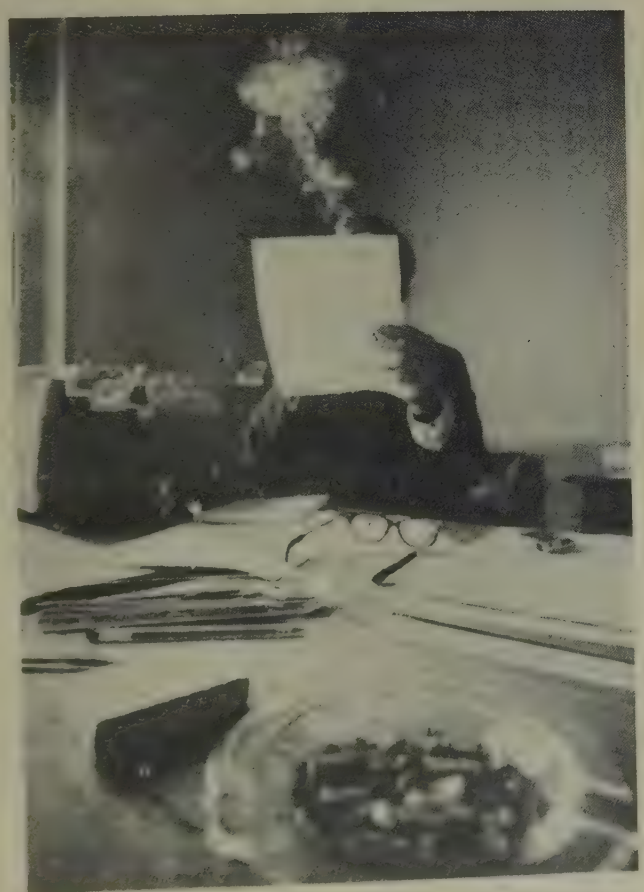


Photo D Ravinder Reddy

'Smoking is injurious to your health' should we take that seriously; and even if smoking is injurious to health do we need to be alarmed when we, as a developing country, are faced with innumerable other problems of poverty and health? I would vehemently respond in the affirmative! We need to be awakened to the growing problem now especially when the developed countries are making heroic efforts in curtailing this bad habit. If so, who then should be the target? Over the last 20 years the developing countries have come to occupy an increasingly important role in output, export, import and consumption. There is therefore every reason to believe that such trends will continue. Tobacco production in the third world has risen at a quicker pace than in developed countries.

As a physician, my concern is for the passive smoker. The issue of breathing others' smoke or 'forced smoking' is becoming increasingly important. Passive smoking can now be said to constitute a true and measureable health hazard and is therefore of legitimate concern. To me, as a paediatrician, my concern is mainly for the pregnant mother who may be herself a smoker, or a passive smoker, for the unborn child, the babe in arms, the little children who are forced into smoking because they have no other choice. This vulnerable group is subject to the habits of parents and are forced to inhale the "sidestream" tobacco smoke and become passive smokers.

A WHO report on indoor air quality stated that "tobacco smoking is still a major threat to the maintainance of indoor air quality." (WHO 1979). Cigarettes produce twice as much sidestream as mainstream smoke and many chemicals are found in greater concentration in the sidestream, often considerably more. Epidemiological studies are beginning to show an increasing rate of lung cancer in non-smokers chronically exposed to cigarette smoke. Asthmatic non-smokers have shown significant decline in respiratory function when exposed to acute levels of sidestream smoke. Long term passive

smokers, those working in confined spaces near smokers, can develop impaired small — airways lung function that is measurably poorer than that of non-smokers not chronically exposed to passive smoking. WHO warned that new studies conclude that children are more vulnerable to illness when their parents smoke.

An increasing amount of data strongly supports the conclusion that smoking interferes with prenatal growth. This growth deficiency appears to be dose —related and is associated with an increased number of spontaneous abortions, late fetal death, neonatal death and prematurity. Hence our greatest concern should be for the expectant mother, whether smoker or not. Besides, the fact that women are smoking and increasingly so, most pregnant women are also passive smokers making both mother and child into smokers. New born babies of smoking mothers are on an average 200 gms lighter than those mothers who are non-smokers. Together with the problem of chronic malnutrition in the majority of our Indian mothers this would be an added problem. You would immediately say 'But our Indian women do not smoke! The appeal of the cigarette is growing with alluring advertisements that are associated with being modern and sophisticated. And the Indian women are now beginning to smoke in greater numbers. 10% Indian women smoke regularly while a greater percentage of the rural women smoke the Indian forms of tobacco. In A.P. the women, more than the men, smoke the chutta which is held with the smouldering end inside the mouth. Bidi smoke, compared to the cigarette, has a higher content of tar, nicotine and other carcinogenic hydrocarbons. The Indian bidis are therefore most harmful of all.

And how many women know that smoking during pregnancy increases the risk of miscarriages, still births and low birth weight babies?

Smoking begins to tell on a child right in the uterus. What has been noted is an acceleration of the heart rate, and a decrease in breathing movements. There has also been some evidence of congenital heart disease in children born to smoking mothers. Besides, there are long term consequences, there is evidence of measurable deficiencies in physical growth, intellectual and emotional development. There is a relatively higher risk of prenatal mortality among Indian women who are anaemic, with high parity in older women. Traditional uses of tobacco in these women can be as hazardous as the cigarette.

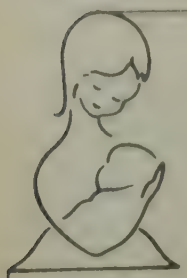
Children involuntarily become smokers. They inhale the sidestream tobacco smoke when either parent smokes, and sidestream smoke does not get diluted as we think. Infact it has almost three and a half times more of benzopyrene.

In the first year of life the risk of the infant developing bronchitis or pneumonia is doubled with parents smoking and wheezing is more common in the under fives.

And what is the future of the child who grows up with either one or both of his parents smoking? While we know of individuals who smoke despite their parents not having smoked, how much easier it is for an adolescent, a child to learn to smoke, given a little time and practice and the example of smoking parents! How easy it is for a son to model himself on his parents, and research shows that parents who smoke exert a definite influence on their children. In families where both parents are smokers 22.2% of the boys and 20.7% of the girls are smokers according to one study. There are, besides, a variety of other factors that induce a child to smoke; these are not just children of the western world. Besides the numberless urchins on our streets and railway platforms who start smoking at a very tender age, we have yet another group of school going children who smoke perhaps more out of peer pressure. Skillful advertising, false claims, glamour and a subtle challenge to greatness has an underlying message to the young to "try it out". While the number of child-smokers at present may be relatively low, in another few years we will have them as "confirmed smokers". It would be best if parents gave up smoking, there would be less chances of children getting addicted to this harmful habit. Can we dream of a generation of non-smokers? And act, to make the dream come true? We can and we must! Remember your child can be worst hit.

Ref: Smoking — Third world Alert Uma Ram Nath.
Paediatrics 17th Edition — Abraham M. Rudolph MD.

School Health



The Seva Ashram Experiment

School Health Programme

Dr S V Rama Rao

School teachers are held in high esteem by Society. They constitute a potential resource of a high order. They happen to be the highest in educated manpower and if properly trained and motivated, they can emerge as effective members of a team to look after the health of school children. A school in an urban slum can render comprehensive service to pupils, teachers and their families. Improvements in children's health cannot be achieved by a school health programme only. Health of the child is the result of much interaction which is diverse and seemingly unrelated.

The Seva Ashram school of Deena Seva Sangha at Srirampuram in Bangalore city started a programme of school health in 1984. The school has a total of 5,000 pupils on the rolls, from nursery to tenth standard. The pupils of the nursery through fourth standard numbering about 2,000 are included. They are of the age group of three years to 10 years. The school is located in a slum area and the majority of the pupils belong to the lower income group,coming from slums. Both father and mother, in a large number of the families, are daily wage earners. The income of the father in most families is not added to the family coffers. So it leaves the mother to take care of the whole family including the father. In the meetings held for parents and teachers, most often it is the mother who turned up, if at all.

The administration of the programme is through a health committee consisting of a chairman, general secretary of the Sangha, coordinator, headmistress of the Kannada and Tamil sections of the school and a secretary of the health committee. The committee can co-opt members whenever found necessary. This committee lays down policies, programmes and arranges for resources and allocation of budget. It also reviews and monitors the progress and discusses problems and suggests remedial measures. It meets at least once in three months but oftener if needed.

Health Team

The health team consists of 20 selected teachers, two link workers or social workers, one co-ordinator and a consultant. The 20 teachers had an orientation training for a period of three months. The link workers have the background of general education which is not less than SSLC or 10th Standard and the experience of having worked as a social worker in some organisation. A qualification in social work is not insisted upon. When an experienced worker is not available, a person is recruited and trained on the job. The coordinator has been a person with the qualification of a health inspector and supervisor with nearly 30 years of experience in the field of public health and comprehensive health care of the community. The consultant in his capacity as chairman of the health committee and leader of the health team acts as a resource person.

The basic philosophy of the programme is:

a) To understand the various problems of health in its widest sense as they emerge and find solutions;

b) Aim at building up healthy children who would remain healthy within the context of their socio-economic, cultural and environmental milieu;

c) That teachers would play the key role (they are equipped with necessary training and orientation;

d) To provide information and knowledge, an understanding of principles of hygiene and health by the pupils;

e) That good health is not just the absence of sickness but the realisation of the full potential of the child in the fields of physical, mental, social and spiritual well-being;

f) That interventions, when health breaks down, are costly and time consuming, besides the fact that chances of full recovery might recede;

g) To recognise ill-health which is a priority. This minimises the adverse effects of sickness that follows, if unchecked. Prompt treatment and follow-up till full recovery is of importance. Without the component of treatment and follow-up, early recognition of ill health becomes meaningless;

h) To recognise and to rehabilitate the physically and mentally handicapped to the extent possible and to the extent resources permit and

i) To document the findings.

Flexible programme

The programme is flexible and has open-ended objectives. Priorities and decision making depend on observations and findings.

The components of the programme received equal attention and covered a comprehensive spectrum. The measures included are:

i) activities under promotion of health;

ii) prevention of specific diseases;

iii) Medical screening and early recognition of diseases followed by necessary intervention to bring the pupil back to as near the normal status of health as possible with adequate and complete treatment;

iv) Special programme for the rehabilitation of the handicapped and

v) Documentation and reporting.

Promotion of Health

Education of children on matters of health was a priority issue. The team gave top priority to personal hygiene. Every opportunity was taken to create awareness and maintain healthy practices and life styles, guiding the children to proper action which meant bringing about an attitudinal change as well as changes in behaviour.

It is a tough task and we cannot say we have succeeded. The didactic approach of education was changed when it was discovered that it made very little dent on the young children.

We changed over to 'situation approach'. The feeding programme, for example; every one was to wash hands with soap and water before taking food. The plates had to be cleaned by children. After eating they had to clean their mouth and teeth. The doctors in the dental clinic had a separate session for oral hygiene. During the medical check-up, children were told the reasons for checking height and weight. When it was less than normal the mother was sent for and informed and the children began to monitor their weight with a spirit of healthy competition.

Frequent questions and answers on all aspects elicited better response and grasp. Some mothers are understanding and responsive. Others just do not bother. It is a challenge as far as the team is concerned. You talk their language, you belong to their religion, you have the same cultural background etc.-everything perfect academically for a good response. But nothing happens. The child forgets or does not consider these health procedures important.

Parents have a very important contribution and the place of enlightened parents cannot be filled up easily. The personal hygiene practices are better inculcated at home, right from birth as daily rituals. Otherwise they lose the sense of values that we try to impose by education.

Prevention of diseases

The immunization programme is another important component. The health team ensures that each child is fully protected against the common childhood diseases of tuberculosis, diptheria, whooping cough, tetanus, poliomyelitis and measles. The Family Planning Association of India (FPAI) has undertaken this immunization. It continues with our full cooperation and documentation. The teacher incharge of the child keeps track and reports. We have not come across children with these preventable diseases.

A feeding programme is a part of the school health programme. Selected children identified during medical check up are included for this feeding. This programme is very popular. Due to lack of resources, we have not been able to admit all children. At 10 a.m. when children have half an hour's interval, they receive one of the preparations which are simple to

prepare, rich in nutrition and fairly cheap. (Groundnuts and jaggery, beaten rice with jaggery and coconut scrapings, germinated grams baked and mixed with masala, plantain and jaggery etc.).

The child's weight is recorded when the child entered the feeding programme and again checked once a month. In all cases we registered considerable gain in weight in each child. We cannot, however, infer that the weight gain is due only to the school feeding. The children are at an age, when rapid growth and development is taking place and secondly the feeding is not continuous throughout the year. They receive it for about 200–220 working days only during the year. Besides this programmed feeding, children are given protein vitamin combination tablets, vit A, B and C as supplements; these are distributed for therapy as well as prophylaxis.

"School teachers are held in high esteem by society. They constitute a potential resource of a high order. They happen to be the highest in educated manpower and if properly trained and motivated, they can emerge as effective members of a team to look after the health of school children".

Frank cases of malnutrition are very rare. In some cases, we sent for the mother and appraised her of the child's condition as regards growth and development and enquired whether the child could be given a glass of milk and an egg (any form) daily. Most often the response is positive and a follow up of child's height and weight is reviewed over a period of time.

The school has protected water supply and arrangements are made to see that the drinking water as a source of infection is eliminated.

Flush-out toilets are provided in adequate numbers but very few children resort to the use of school toilets.

Medical screening and follow-up

Early diagnosis of conditions which may forecast an on-coming disease or a condition hitherto unsuspected is first made by the observant teacher. The teacher reports to one of the members of the team. These include red eyes, running in the nose, fever, defective vision, hard of hearing, caries teeth, skin conditions (like urticaria, scabies, ulcers, angular stomatitis), behavioural problems (like failure to learn, difficulties in adjustment with other children, frequent absentism) etc. Chronic conditions include pus coming out of the ear (chronic otitis), something wrong with the eye (chronic dacryocystitis), upper respiratory infections, shortness of breath, puffy eyes etc. These children are brought to the school clinic for further examinations, investigations, treatment or referrals.

The school clinic is open on all working days during working hours. Emergencies and first aid are provided. All teachers are qualified in first aid. The medical officer attends the clinic once a week when 30 to 40 children are given a thorough medical check-up. He attends to all children referred by the teachers and team. Referrals are given to parents whenever needed and follow-up maintained. Each child gets two check-ups at least, once when the child enters school and once when the child leaves the IVth standard. Full particulars are documented.

The highest morbidity was observed in the dental field. Nearly 25% to 27% of children, have caries teeth. The condition is seen in deciduous teeth mostly. Arrangements for running a weekly dental clinic in the school premises has been made. The department of preventive dentistry in the Government Dental College depute the specialists who not only treat conditions but have a session for inculcating practices for improving oral hygiene. On an average 20 to 30 children report at the dental clinic with their parents.

The Institute of Speech and Hearing screen the children for detecting the defects in hearing and speech and children found with a handicap are

referred, treated and followed up through-out.

The Regional Institite of Opthalmology (Minto Hospital) caters to the visually handicapped. The doctors come and screen all the available children at school and thereafter the preliminary screening for vision is done during the routine check-up and referred as found necessary.

A total of 27 orthopaedically handicapped have been identified. Detailed examinations and course of treatment to be followed have been laid down by the Orthopaedic Specialists of the St. John's Medical College. These children are being followed up. So far only five children have been fully rehabilitated. It is a very difficult task to presuade the parents to do what is necessary.

"The programme is flexible and has open-minded objectives. Priorities and decision making depend on observations and findings."

One of the intractable problems is the chronic otitis media. Nearly 26 children have been found to suffer and the usual treatment having failed, they have been referred to ENT specialists who have done their best. Repeated mild throat infections and common cold have been responsible mostly for the perpetuation of infection via the eustachean tube.

No malnutrition

As already stated, frank cases of malnutrition were not encountered. Specific deficiencies of vitamin were not observed, except angular stomatitis. Five percent to six percent of the children examined at the first session have shown suspicions of underdevelopment and growth. Height and weight alone does not give a correct picture. Supplemental feeding, administration of Vitamin-protein tablets, along with minerals like iron, folic acid and calcium tablets have been undertaken.

Documentation:

Simple proforma with useful information only has been designed. Apart from information on full identification of the child, the forms allow recording of particulars of growth and development, immunizations, details of diet and drug supplements issued. Provision is made for recording relevent information during first medical check-up, deviations, action taken and full follow-up, particulars. Each child has this information in the file with a distinct code number.

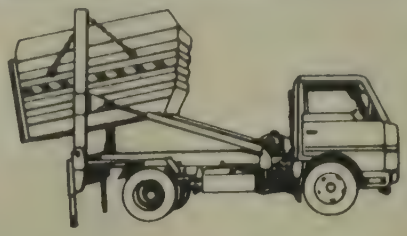
The programme has achieved its objective of drawing attention to various problems. These problems are the result of interaction of a very diversified nature. Improvements in children's health cannot be achieved by a school health programme alone.

The health of the child is the result of much interaction which is diverse and seemingly unrelated, from consumer goods to child labour and sexual assaults — there is no end to it. A child's health is being talked of in every forum and is on the agenda of many national and international organizations and they have always ended in mostly dialogues and with declarations that child health should receive priority.

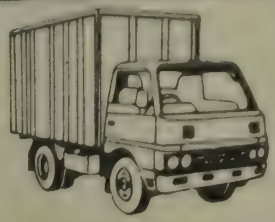
In India, it has been accorded the highest priority in the social welfare sector of the five year plans. There is a national policy for children and the government has initiated in 1975, a scheme called "Integrated Child Development Service Scheme". This scheme is directed towards preschool children who are difficult to get at. It is a package services approach and includes antenatals and postnatals, along with women of the age group of 15 to 44 years.

Our experience shows that enlightened parents hold the key to the problem. Children are vulnerable victims of many exploitations by unscrupulous elements. Unless there is a political will to really do something concrete for the children, one has to wait for a long time. It is necessary that those concerned and those in authority realise that the child's name is Today. We must do what we should, to build tomorrow's world. A child cannot wait.

* **Minibus:** unbeatable comfort, unbeatable economy. 16-seater Deluxe/9-seater Luxury Coach.



Dumper Placer : unbeatable speed and manoeuvrability - Faster clearing of garbage containers from narrow lanes.

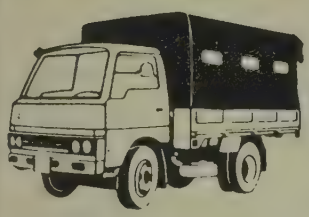


Aluminium Body Delivery Van: unbeatable safety, unbeatable economy.
Better fuel economy on account of lesser body weight. Also available as Milk Van.

* **Ambulance:** unbeatable speed, unbeatable safety. Fitted with a medicine chest, hooks for saline bottles, stretchers, attender seats and provision for oxygen cylinders – to mention a few.

The unbeatable performer in an unbeatable range

Water Tanker: detachable tanks for unbeatable flexibility and convenience.
Can also be used as a Pick-up Truck during off-season.



* **Soft-top Police Van:** unbeatable power for an all-terrain performance Tough and efficient; packed with power – at a lower price.

Refuse Compactor: unbeatable manoeuvrability in narrow lanes
Unique closed body for better hygiene.
Hydraulically operated loading, compaction and ejection.

• Pick up *• Cabin & Chassis *• Cowl & Chassis*

MAHINDRA NISSAN ALLWYN CABSTAR

* Available on DGS & D rate contract

* **Hard-top Police Van:** for unbeatable power and safety. Also available as Cash Van and Mail Van.

Water Tender: large fire -engine benefits at an unbeatably low price. Compact and manoeuvrable, it can be placed very close to the fire fighting area.

MAHINDRA NISSAN ALLWYN LTD

NISSAN

R K SWAMY/MNAL/121-89

The health of the school child

Dr B.R. Rama Rao

"Train a man and you train an individual
Train a woman and you build a nation"

Bishop Nzimbe
Machakos, Kenya
May, 1985

"We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer "tomorrow" His name is "Today".

Gabriela Mistral
Nobel Pirze-winning poet from Chile

In our world, four out of ten women are illiterate. The health and well being of the family is highly dependent on the literacy of the mother.

Schools do not keep pace with the population growth. The growth of population brings school age children faster than education services grow. Due to growth in population for every three children who could not find places in schools in the seventies, there are likely to be four or more without schooling in the eighties. Forty percent of our population is under 14 years of age. To maintain the present level of education our country needs 1,27,000 new schools every year and 3,73,000 extra teachers. The health expenditure in India is only 0.13 rupees per head per year: cost of one aspirin! And what about school health services ? There is no organised school health services in our coutnry.

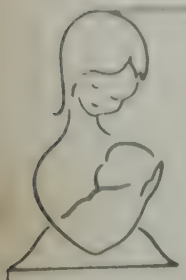
In lectures by Sir Alan Moncrieff, Nuffield Professor of child health, University of London in 1953, he said about school health that "Britain holds a premier position in the magnitude of its universal distribution of its curative medical work for school children". In England in 1890, a school medical officer was appointed in London and a few years later in Bradford which also had the distinction of opening the first school clinic in England in 1908. By 1905 school medical officers had been employed by local education authorities. Medical inspection of school children had been started in 48 areas. Nurses in schools have been employed mainly by voluntary support. A compulsory medical inspection in England showed that there was a large amount of disease and defects in school children. Our country has yet to come to grips with this problem".

The objective of school health services is to provide and promote the health and welfare of the school child with special emphasis on the ability of the child to derive the maximum benefit from the education provided.

The duties of Medical Officers incharge of School Health Services: will comprise of (1) Medical inspection of schools (2) The conduct of school clinics (3) Occasional special visits to schools or homes of children to make special reports or when there are outbreaks of infectious diseases.

School Medical inspection:

The object is to assess the health of each child and to assess the degree to which it is capable of improvement: to note defects and to take steps to



remedy these when possible; to educate parents, children, and school teachers in health matters. Such examination must be made compulsory by the law of the State. The Government and school authorities, and parents must be made to abide by it. The children to be covered by medical examination should include (1) Nursery school children who will require an annual comprehensive examination. (2) Primary school children, who will have a medical examination immediately after admission usually at the age of five years and during their last year at the age of 10 years. (3) Secondary school children at their 12th birthday and when they attain 15 years and during their last year of secondary school. There must be a reasonable frequent periodic examination of all school children.

Requirements

All schools must provide an examination room: spacious, well furnished and with a wash basin, stethoscope, autoscope, throat spatulae, sterillizers, blood pressure apparatus, height and weight machines and a mid arm circumference tape. There must preferably be a waiting room for parents and teachers and a nurse to help the doctor with proper medical records. Medical inspection shall not become a boring and repetitive routine. It should establish a close contact with parents and use the time for constructive preventive work. Half an hour per child is not too long for a complete examination of an apparently healthy child to exclude all defects. A medical examination of a child can never be reasonably complete unless a parent or responsible adult who knows the child intimately is present.

This consists in a physical examination of the child. Note the height, weight and mid-arm circumference to get an indication of the nutrition of the child. Examine the scalp for lice, skin for ring worm infections, scabies, and other skin infections which are common in children of school going age; an ear, nose and throat examination for running of the nose, middle ear infection, wax in the ears and deafness. If the child is partially deaf, assess the deafness with audiometry and help the child's hearing with hearing aid. Consult the school teacher regarding the seating of the child so that the child could get the maximum benefit of hearing. The child should be recommended for training in hearing. Transfering the child to a special school for the deaf and partially deaf becomes necessary if the child cannot keep pace in learning with other children.

Defective vision apart from squint occupies one of the highest places among conditions requiring treatment. An attempt should be made to test the vision of the child as soon as possible after entry into school. Test card or pictorial charts designed for non-readers may be used.

If the school teacher or nurse has any doubt about an individual child that child should be referred to an eye specialist. Delay in learning his letters may be result of visual defect. A good screening procedure will pick up the greatest number of children who require observation and treatment. Children should also be tested for colour vision. Children with squint can be spotted at a routine school health checkup; they may require correction with glasses, eye exercises or surgery.

Medical inspection of school children includes dental inspection. A dental service closely associated with the educational system is the most effective arrangement for ensuring that the maximum number of school children obtain regular dental treatment. Individual children may seek treatment, if their parents so desire from a dentist working in general dental service.

Handicapped children

Special schools for the handicapped children should be thought of in our country. There is need for schools which will cater for the:

Blind and partially sighted;
Deaf and partially deaf;
Educationally subnormal;
Physically handicapped and delicate;
Maladjusted;
Epileptics, and children with speech defects.

For the handicapped child the normal field of opportunity should be open to the fullest extent befitting the nature and extent of his disability. Handicapped children have a deep longing to achieve as much independence as possible within the normal community instead of being surrounded by an atmosphere of disability. Their handicap especially in an older child carries with it a danger of

psychological and emotional disturbance resulting in a sense of frustration and deprivation. If they are surrounded by a normal environment and are treated with understanding, the child succeeds in developing his or her residual resoruces to an unexpected degree, in becoming an asset to the community. It is sometimes difficult to assess whether a handicapped child should attend normal school or a special school. The problem becomes more acute in a child who is suffering from a physical handicap so severe as to prevent real mobility. They require more attention and may create a burden for the teacher. Handicapped children, apart from those who are educationally subnormal by reason of limited intelligence, tend to be slow learners because of absence from school on account of frequent medical and surgical treatment. They may require more individual attention from the teacher which may be detrimental to the other students.

All concerned persons need to realise that the claims of handicapped children to normal surroundings in an ordinary school must be given due weight. The objective is to help them to take their place in a normal community when they grow up. When they are admitted to ordinary schools, medical officers should periodically check from the teachers about their progress and whether they display emotional upsets. A handicapped child should never be removed from the home and school unless it is absolutely essential. A home is important to children, even a bad one. A handicapped child wants to do things himself even if it takes a long time and he resents things being done for him. The circumstances of the school must suit the child and the child must suit the school. The type of school requires equal consideration. Old and dingy buildings in overcrowded surroundings would be inappropriate for delicate or handicapped children. A school with two or more storeys is scarcely the kind of school to which a severely disabled child, or a child with damaged heart should be sent. While placing children in schools, each handicapped child must be considered individually.

Blind Children

Practically every blind child must be educated in a special school. Occasionally a blind child may make such progress that he may attend an ordinary school and learn with the aid of Braille and reading aloud from text-books by other persons.

Partially sighted children

Recently much wider field has been opened up for such children with advice from eye specialists. They can attend ordinary schools where there is good lighting, natural or artificial. The child can be placed in a favourable position in the class. The more intelligent partially sighted are remarkably successful in overcoming their handicap.

Deaf Children

Deafness in children is being increasingly diagnosed in infancy. With early training in lip reading and use of hearing aids together with initial education at home more children can be expected to attend ordinary schools. If the child does not progress

in an ordinary school, the child may be transferred to a school for deaf children where special teaching facilities are available.

Educationally subnormal children

They constitute by far the largest group of handicapped children and present the biggest problem in ordinary schools. Differenciation should be made between backwardness due to innate cause and those not due to innate causes. The dull child requires education appropriate to his or her mental and not chronological age. Provided there are no behavioural problems and dullness is not of very low level these children may be educated in normal schools. They should have, if possible, a normal environment in which to progress within their limitations.

Epileptic children

When placing them in schools, account should be taken of the severity and frequency of fits and the extent of intellectual retardation and problems of behaviour. Epilepsy is not necessarily associated with mental retardation and the sufferers are not different from normal children. They should be able to attend a normal school and lead a normal life at home. Usually they do not have fits in the school. In any case if they had a fit in the school, it is an opportunity to teach the students the value of calmness in the face of a medical emergency and give aid to such a child.

Maladjusted children

The causes for maladjustment are numerous and complex. They may be an environmental situation in school or at home, educational difficulties, psychological imbalance from physical or mental handicaps or from biological conditions. The majority of such children can be educated in an ordinary school. At no cost should such a child be removed from the family unit. The school child guidance service can help them.

Physically handicapped child

The majority can be educated in an ordinary school. Sometimes restrictions from out of class activities may be needed depending on their handicap. Adjusting such children to an ordinary school is a challenge to the doctor and the teacher. Physically handicapped who are ambulant raise no problem. If there are problems in mobility, the teacher and the other students should be sympathetic and help the child.

Children with speech defect

They can be educated in an ordinary school. Their handicap can be treated with a speech therapist working in close association with school health service.

Delicate and diabetic children

A delicate child with severe asthama or bronchitis may benefit for some time with special schools like open air schools and later may attend an ordinary school. Diabetic children can attend ordinary schools. The teacher must be told about the emergencies, though remote, that can occur, like a fall in blood sugar level or diabetic coma and how to tackle the emergency.

Teacher !

Here's how you can help !

Detection of minor ailments and defects in School Children

Dr K R Antony, B.Sc., MBBS, DCH, DTCH

Awakening of health consciousness of pupils and school teachers leading to promotion of positive health and provision of a healthful environment is the prime objective of school health service. To achieve this objective some of the activities to be undertaken are in the area of prevention of communicable diseases and in the early diagnosis and treatment of illnesses.

The School teacher is the most important person in whom a child sees the "Parent figure" away from home. The teacher has got tremendous influence on

him because of the "emotional bonding" that takes place between him and the pupil. In fact some children accept the authority of opinion of teachers above their own parents on matters of general knowledge. They have got so much over faith in the "infallibility" of their teachers however less qualified that teacher is than the child's father or mother. This key "suggestion role" or "influencing factor" has to be made use of in inculcating healthy habits and an outlook for positive health.

Once students are convinced about the dangerous effects of many unhygienic practises and advantages of exercise, good nutrition etc., they will carry home these messages. They become the "ambassadors" of positive health from the school.

Every school going child must know that a healthy surrounding is a necessity for his/her proper growth. A child must realise that health is his/her birth right, and to ensure this right his/her parents and teachers are trying their level best. But in this effort children also must contribute their share. School Health is a very economical and powerful means of inculcating the concepts of community health among future generations.

In many places school health narrows down to health appraisal of pupil as "medical check up camps". The School Health Committee (1961) in India recommended medical examination of children at the time of entry and thereafter every 4 years. A medical team coming from the nearest taluk or district hospital in the morning and finishing the medical examination of all children before 4 PM becomes more of a social activity than serving the purpose. A hastened screening deteriorates into just filling up of some records and a customary auscultation of chest. It is a matter of sheer luck if congenital heart diseases, defects of vision and hearing, border line mental retardation etc. are detected in such camps. It is in this context that the role of school teacher as a health worker attains importance.

Observation of Pupil:

Apart from the influencing role the teacher has he is in a unique position to carry out continuous observation of children. At least 5 days a week 6 hours a day he is watching them sitting, standing, walking, playing and interacting with other children. He can easily pick up which child is not well or 'upto the mark' in day to day activity. You do not require extra skill for that. Some basic knowledge of common illnesses, a keen observation power and a skill to compare one child to another child will suffice to make a school teacher an excellent health worker.

Is Aswin a healthy pupil? If he is healthy he gets along well with himself and other persons. He has an abundance of vitality. He is happy and smiles easily showing clean, straight teeth. His skin is clear and his hair is lustrous. He has good muscle tone and body mechanics that provide satisfactory standing, sitting and walking postures. He participates in many types of physical activity and is developing leisure time activities. He has safety skills that prevent unnecessary injuries. His eyes are bright and clear, and his hearing is acute. He gets sufficient sleep, has daily periods of rest and has a hearty appetite, and gains weight and height as his growth patterns change. He has developed daily habits and control of elimination. He has no illnesses and has had his remediable health difficulties corrected. When he has an irremediable health condition, he has made adjustments in daily living. He has a wholesome outlook on life and is willing to seek assistance when emotional health problems arise.

The teacher's observations are not limited to morning inspections but are continuous throughout the school day. Nor can these observations be confined to signs of communicable diseases, but must include every phase of the whole child — mental and physical health, social characteristics, intellectual capacities, and achievements.

As the teachers observe — any sign of health problems, they should compile their data so that differences among pupils can be compared. Bodily growth, skin conditions, posture habits, fatigue and energy levels, appetites, visual and hearing difficulties, dental health problems, bodily cleanliness, and emotional health problems of two girls of the same age will reveal distinct variations in observable signs. These observations should be continued over a reasonable period of time so that deviations can be detected.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad 500 003. Ph: 841610

Types of signs:

First there may be signs of health problems that are repeated regardless of the disease or defect. Fatigue, irritability, listlessness, failure to achieve capacity of work, apathy, loss of appetite, and slumped posture may be common to many health problems. Second, there are specific signs that identify each health problem. Third, health problems may be interrelated. Signs of a hearing difficulty may be one of the causes of an emotional health problem. Fourth, the signs of diseases and defects and some of the signs observable to nonmedically trained persons, like teachers.

Some signs of possible Communicable diseases:

Reference — School Health Programme
By Jessie Helen Haag
Calcutta, Oxford & IBH 1968

—Unusual pallor or flushing of the face;
—Inflammation (redness, soreness, heat, pain) of the mucous membranes of the nose, throat, and mouth;
—Inflamed and watery eyes
—"Runny nose"
—Sneezing, coughing, sniffling
—Swelling or tenderness of the glands of the neck
—Unusual apathy/Disinclination to play
—Faintness, nausea, or vomiting
—Fever or chills
—Headache
—"Runny ear"
—Loss of appetite
—Tiredness
—Irritability
—Below-par school work
—Upset stomach
—Stiff neck
—Backache/Bodyache
—Noisy breathing, wheeze, grunting etc.
—Blueness of lips
—(Vesicles or Redspots appearing on face, neck, chest, arms of child)

Some Signs of Possible Visual Difficulties

—Rubbing of the eyes
—Continual frowning
—Blinking more than usual
—Position of the book held in reading too close or too far away
—Sensitivity to light
Inattention
Red-rimmed and watery eyes
—Swollen eyelids
Repeated styes
—Complaints of dizziness
—Stumbling and tripping over objects
—Shutting or covering of one eye when reading
—Tendency to reverse words or syllables
—Excessive head movements while reading
—Body rigid while looking at close objects
—Complaints of headaches
—Susceptibility to fatigue
—Difficulty in distinguishing colours
—Request to have writing on chalkboard repeated orally
—Irritability
—Dislike of assignments requiring close work
—Drawings described in a confused manner
—Difficulty in reading (reads only briefly without stopping or loses place)
—Screwing up of face when reading
—Poor hand-eye coordination
—Poor score on accuracy tests such as target throwing
—Complaints of seeing objects in double vision
—Head turned to one side when reading or writing
—Unnatural position of the head in an attempt to avoid glare
—Squinting
—Voluntarily changes in his location, to see better;
—Crusted eyelids
—Inability to distinguish symbols nearly similar in appearance such as "a" and "o", "e" and "c" "m" and "n", "n"and "r", "f" and "t", 8 and 6, 7 and 1, 3 and 8
—Crossed eyes
—Erratic eye movements
—Body tenseness during class work
—Loss of peripheral vision
—Head thrust forward

Some Signs of Possible Hearing Difficulties:

—Requests for repetition of what has been said
—Complaints of earaches
—"runny ear"
—Complaints of noises in the head, such as ringing, buzzing, hissing
—Breathing through mouth

—Peculiar-sounding voice (pitch too high, too low, too loud)
—Complaints of heaviness, stuffiness, or fullness in the ear
—Cocking of an ear toward the speaker
—Repeatedly answering questions incorrectly
—Sensitivity
—Suspiciousness
—Aloofness
—Failure to locate source of sound — Watching other children before beginning to work or copies from other pupils
—Bewildered facial expression
—Use of his hands in making known his wants
—A look of "watchful waiting"
—Below-par school work
—Close attachment to the teacher during group activities — "Shadowing" of the teacher
—Poor sense of balance
—Monotonous speaking and singing
—Faulty articulation
—Tendency to lip read
—Efforts to lip read
—Hand held to ear
—Observing other pupils during teacher's directions
—Interrupting conversations of other pupils

Some signs of Possible Emotional Health Problems:

—Undue restlessness such as facial grimacing, nail biting, lip sucking, twisting or pulling the hair, pulling the ear, playing with hands not attributable to any observable physical cause
—Excessive day dreaming
—Persistent inattentiveness
—Extreme sensitivity
—Crying easily
—Overtimidity, seclusiveness, extreme docility, withdrawal
—Overaggressiveness, extreme "showing off"
—Resistance to authority
—Complaints of being "picked on", not being treated fairly, or being discriminated against — Antagonism — Poor sportsmanship
—Difficulty in reading or reciting not caused by any observable physical cause
—Poor school work inspite of good health and adequate intellectual capacity
—Chronic absence
—Continual lying
—Lack of cooperation (negative attitude)
—Frequent bullying
—Continual selfishness
—Unacceptable sexual conduct
—Temper tantrums
—Destructiveness
—Cruelty
—Uncontrollable emotions
—Over studiousness
—Domineering attitude
—Depression and unhappiness
—Listlessness
—Lack of respect for the property of others
—Obstinacy
—Stealing, cheating

Some Signs of Possible Nutritional Deficiencies:

—Failure to show a steady gain in weight. Monthly weight monitoring is necessary
—Lack of appetite or finicky appetite
—Avoidance of normal play activities
—Poor postural habits — round shoulders
—Susceptibility to fatigue — Complaints of pains on sitting and standing
—Chronic diarrhoea or constipation
—Repeated respiratory infections
—Persistent cracking and slight redness at the corners of the mouth
—Small or flabby muscles
—Excessive thinness
—Excessively fat or poor distribution of fat on body surfaces
—Strained, worried look
—Listlessness and inactivity
—Irritability and difficulty in managing
—Poor dental health
—Pallor
—Continual hunger
—Abnormalities in bone growth — bowlegs, pigeon breast
—Rough, scaly skin
—Dry, coarse, brittle, lusterless hair
—Inflammation of margins of eyelids
—Headaches
—Eye fatigue and sensitivity to light
—Tender, swollen, bleeding, or spongy gums

—Easily bruised skin
—Sore joints
—Pains in the musculature
—Apathy
—Sore, beefy tongue
—Spindly arms and legs, flat chest, Prominent ribs which can be counted
—Abnormalcy in discharge of tears
—Weakness and loss of strength
—Skin abrasions slow to heal
—Brittle nails
—Burning and prickling of skin
—Burning or itching of eyes
—Difficulty to read in the night.

Some Signs of Possible Dental Health Problems:

—Swollen jaws
—Evidence of tooth decay
—Poor oral habits, such as thumb sucking, nail biting
—Toothache
—Tartar
—Bleeding gums
—Malocclusions
—Bad breath
—Ulcerated gums
—Brown or black spots at edge of tooth
—Unusual placement of teeth
—Use of only one side of the mouth for chewing
—Refusal to eat hard food
—Abnormal sucking
—Loose teeth

Some Signs of Possible Posture Conditions:

I Standing Posture — Round shoulders

—Sway-neck
—One shoulder higher than other
—One hip prominent
—Markedly inclined head
—Markedly depressed or deformed chest
—Knock-knees or knees extended back
—Bowlegs
—Flat feet
—Protruding shoulder blades
Protruding and sagging abdomen
Toes pointed outward, ankles turned inward, body weight on inner side of feet
General body appearance — slumping
Weight on one foot
Uneven walking gait.

II Sitting Posture:

—Slumping over so that the child is sitting on the end of the spine
—Hunching over
—Leaning to one side because chair arm is too high
—Curling one foot under the body
—Not placing feet on the floor.

Follow-up:

What to do if the teacher has observed "something wrong"? Don't ignore your doubt. May be it is a very valid observation pointing to a grave illness or an underlying defect. Even if it turns out to be insignificant it is fine. Don't feel shy to report what you found abnormal.

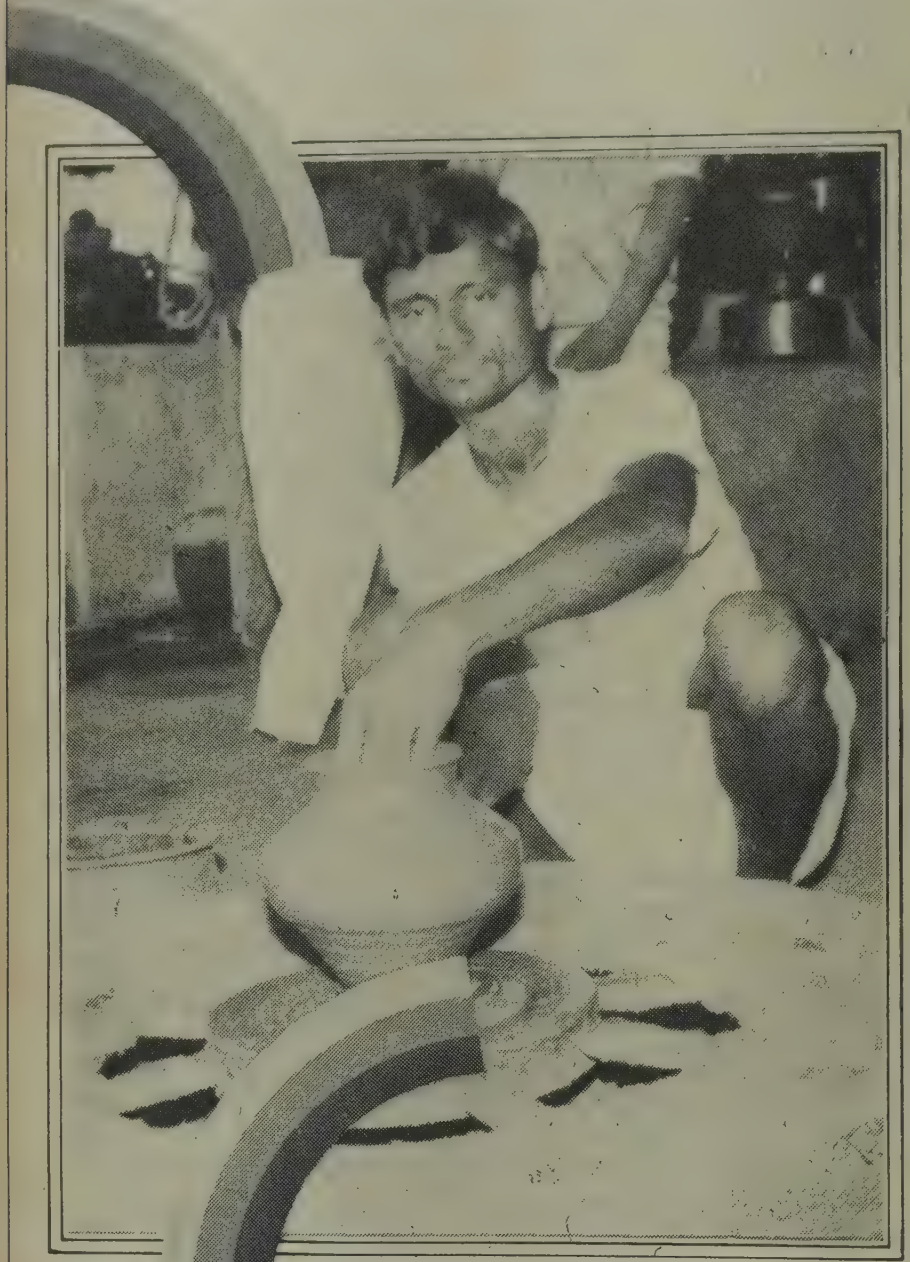
In my opinion a teacher must take the child's parents into confidence. Share with them your concern. Make sure they got the seriousness of the problem adequately. Some will over react, some might play it down. Financial constraints may be one of the reasons for not going to a doctor for detailed check up and investigations. If it is sheer callousness of parents that delays the follow up care, be after them till the child gets his basic right of adequate medical care.

If there is a regular health worker from the nearest PHC visiting your school you can entrust her to the pupil for a check up by the medical officer there. If the annual school medical check up is near you can bring to the notice of the team of doctors visiting you these "problem students" for special attention.

Once the child is investigated and a diagnosis is arrived at still the teacher must keep in touch with parents to ensure that remedial measures are taken up e.g., whether spectacles are purchased or not, whether he is taking regularly his antiepileptic pills or not, whether he is going regularly for his dental care appointments etc.

School Health is an activity where the school teacher/teachers, applies in practice and demonstrates what he teaches and also becomes a "provider of care and service" based on what he knows.

Beyond Business



Come to think of it, our work in villages has taught us much about rural development. For what we found were communities which were already well developed, socially, economically and even technologically. Our contribution to rural development is to use this knowledge of local needs and conditions, to suggest changes by which the local resources become more productive, the local human skill can be less laborious and better employed. For example, developing and inducting improved kilns and wheels for potters.

Or lining of village ponds and reservoirs with plastic films for better harvesting and preservation of rain water. Working out a polymer coating to protect mud walls of village huts from rain and insects.

In essence, we do not adopt villages. Ours is a qualitative relationship, not of patronage and dependence, but of acceptance and mutual regard, for socio-economic betterment and improving the quality of life. Our reward is a sense of fulfilment as partners in progress. And our quest for such interactions and initiatives continues and will continue.

IPCL

A Partner in Progress

Indian Petrochemicals Corporation Limited
(A Government of India Undertaking)
P.O. Petrochemicals Township, Vadodara 391 345.

Aadharshila:104:89

Regional Offices: • Air India Building, 19th Floor, Nariman Point, Bombay 400 021. • Ralla Ram Building, 70, Mission Road, Bangalore 560 027. • AG - Tower, 7th Floor, 125/1, Park Street, Calcutta 700 017. • Ashoka Estate, 10th Floor, 24, Barakhamba Road, New Delhi 110 001. • Kirti Towers, 9th Floor, Tilak Road, Vadodara 390 001.

THE SORROWS OF SCHOOL

"Never let school interfere with your education"

— Mark Twain

School is a bad word. At least, for the majority of the millions of the country's children completing the mandatory 10 to 12 years before standing at the threshold of the adult world, testing out what it has in store for them. Tragically, more often than not they emerge from the experience utterly bored, the edge of their natural curiosity blunted by an unimaginative learning regimen.

At present, these victims of an appalling system which strains to pass off as education must wish they had heeded Twain's words of caution. It would be rather unfair to discount some of the commendable efforts made at rearranging the scenario to bring in the sorely needed changes. This crying need has, to a certain extent, been met by individual experiments using alternative training methods. These were

successful but lost their impact since they have been instances so stray and scattered. So that a few cases of pioneering educationists and lay persons putting innovative ideas into practice cause nary a ripple in the cesspool that is the overall system.

A total revamping is called for. Far from adhering to that idea of expanding the intellect, schooling today, in fact dangerously stifles a great amount of the vibrancy of a growing child. This it achieves through a phased programme of rote learning of a syllabus usually unrelated either to further studies or life outside. Add to that the typical bureaucratic bungling of lofty education policies, harassed teachers, over-ambitious parents, plus, obviously, the exhausted children themselves and you have a completely murky picture.

Why the pathetic state of affairs? And what could serve as a way out? Simple enough questions to raise. The government thought it could creditably answer them. With a staggering Rs 6,200 crore outlay proposed for education in the last plan it was a large-scale investment, next only to defence expenditure. Then again, the much-trumpeted New Educational Policy (NEP) resolved to ensure that "all children who attain the age of 11 years by 1990 will have had five years of schooling or its equivalent through the non-formal system", extending the target date for universalisation of primary education to 1995.

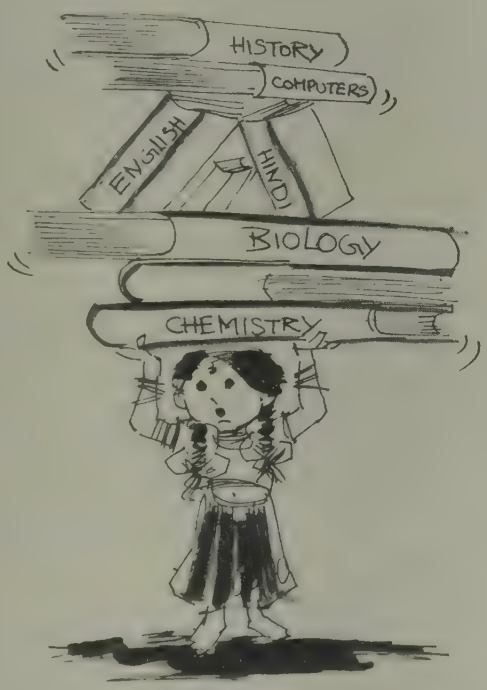
Next, Operation Blackboard, the mainstay of the NEP-recommended programme, was launched on almost a war footing. The "operation's three-pronged approach seeks basically to provide a two-room concrete structure for every primary school, to recruit a second teacher for such schools where there

is only one teacher (Maharashtra alone is said to have 16,500 of these) and provide some minimum equipment for the working of the schools. Blackboards apart, the long list of equipment to be provided includes maps, musical instruments, science kits, dictionaries and reference books for library, furniture, mats, toys and sports equipment.

Yet, actually implementing these well-intentioned schemes so grandiose sounding on paper, has proved a Herculean task. Consider the following news item appearing in **The Times of India** in August last year- "Owing to financial constraints, the targets for Operation Blackboard for the current financial year have to be reduced, the Rajya Sabha was told by the minister of state for human resource development..."

And so it goes on, the same old story.

Until as recently as the early eighties, what teachers today refer to as the school anxiety syndrome was not so pronounced. Yes, parents worried a little before children were admitted to a school. But that was about it. Now, at the end of the same decade, the situation has taken on more dangerous dimensions. What is worse, the children themselves become tense, bordering on the paranoid, when it is time to enter the great education bazaar. Absurd as it may sound, there is actually the practice- and a thriving one at that-of coaching classes to train three-year-olds for kindergarten interviews!



So strongly is the competitive edge of the experience driven into them that often, at the moment to prove themsevles, children who might have sailed through the interview, had they been left alone, either clam up or stammer out all the wrong responses. Comments Vaishali Rajapurkar, a young mother from Pune who went through the gruelling process, "My son drove us crazy with his constant questioning; 'what will I do if I don't pass and go to school?' It's a ghastly business".

As for the nightmarish admission waiting-list, there has reached a stage when pregnant women desperately enrol in a couple of co-educational schools, playing it safe, the child put down on some roster or other. Dubious "donations" and serpentine queues for admission, in which even grandparents, having got into the act, wait overnight, are all part and parcel of the mad scramble.

Chitra Pandit, a former teacher at St Anthony's High School in north Bombay, lays the blame for school trauma squarely at the parent's door. "As teachers we realise the limitations of the whole business. It is parents who must have the guts to break away. But it's they who succumb to the trap, fall in with everything lamely. They're on this unending ego trip. My child came through with flying colours, my child topped the batch, my child learns from a tutor on whom I spend an extra Rs. 300 fees... It feels nice to bask in reflected glory at the cost of the poor kid's psychological well-being" So that this sad keeping-up-with-the-Joneses malaise afflicting parents evokes heart-rending reactions from the children. One little girl, too afraid of the consequences to risk identification, remarks, "Oh, I have three teachers. One in school and two at home. Mummy and papa make me sit down for homework the minute I return from school". Like thousands of others in the same boat, she is pushed against her will and beyond her capacity, driven hard by over-ambitious adults. Nina Bilimoria who takes languages and social studies at the Cathedral and John Connon Middle School, Bombay. agrees that there are parents who are "completely marks-obsessed. They come to demand the extra half mark if it makes a grade difference. It's terrible on the child. Nothing he does seems good enough".

Parents shrug off the accusations with a we-can't help-it, wait- till-you're-in the-same-rut attitude. Or

claim children are not as badly off as made out, and life being as complex as it is, they must, can and do cope. "Kids have got what it takes. Compared with my days, what's taught to my son is definitely heavier", says Padmaja Parate, a Madras housewife, "but children today are equipped to absorb the bigger load".

Again, Camelia Satija, Delhi-based business woman and mother of two daughters declares, "They're producing robots. Such products will only be warring against each other. Competing for places, jostling for job posts afterwards".

Countering the charge of excessive work pressure on school goers, Prof P N Dave, head of the department of pre-school and elementary education, National Council for Educational Research and Training (NCERT) observes, "The Early Childhood Care and Education (ECCE) schedule provides a holistic approach. It is the best we have at this juncture. You should see the past-from where we have come and where we are going. Some other third world countries don't even have an ECCE plan". Some reasoning! Few children are likely to buy that logic. Eleven-year-old Ramesh Rao from Poorna Prajna High School in Bangalore, for example, is firm in his views: "They tell me so many tests are for my own good, that I will grow to be an intelligent man. I would not mind sacrificing some of the intelligence if only I could have more free time now!". Or as seven-year-old Shazia Rajan from St Louis Convent, Bombay, says, "I hate studying only because there's so much of it. Otherwise, school is fine".

Homework, then, is the bane of every schoolchild's existence. And, seeing that these days additional tution for every subject is considered absolutely essential right from standard I, there are two sets of matter to tackle, school and tuition class homework. Most schools think nothing of forcing children to walk weighed under the load of their bags.

Which is why Reagan D'Sa has fast acquired a bad bone problem in his right shoulder. Under medical treatment to remedy it, the eight year-old who says "I look like a camel walking to St Andrew's" has a servant tag alongside to lift the bagful.

Two factors held responsilbe for the tuition menace are the increase in the number of working mothers and the distintegration of the age-old joint family. Away from home most of the day, anxious parents often compensate for the guilt they feel by overdoing the strict disciplinary bit. This does tend to transform them into slavedrivers of sorts, insisting on long hours of homework and tuition attendance put in. The quality of attention is ignored. As is the negligence of the rest of the child's personality.

Joan Dev, headmistress, Cathedral Junior School, holds she has nothing against tuition in school to help weaker children, "but when it comes down to going from house to house for an hour or so and charging the earth for that, it's undignified, cheap, downright degrading, a kind of prostitution, I'd say. "Also decrying the two-shift system, Dev admits that the pressure of numbers necessitates it in many schools.

Sixty to 70 children crammed sardine-like in a classroom with one teacher in charge clearly reflects the fact that the number of schools opened simply does not keep pace with the children clamouring for admission. What is possible, then, but has yet to be implemented, of course, is an experiment successfully carried out in Singapore. Rotating shifts.

The batch of students forming the morning shift one term attends afternoon school the next and vice versa. This gives every child a chance to work mornings, which is ideal. Afternoon shift children have been found to perform more poorly, having had to absorb large chunks of information with a tired mind. It is common knowledge that grasp and retention are generally better during the first part of the day, even in the case of adults.

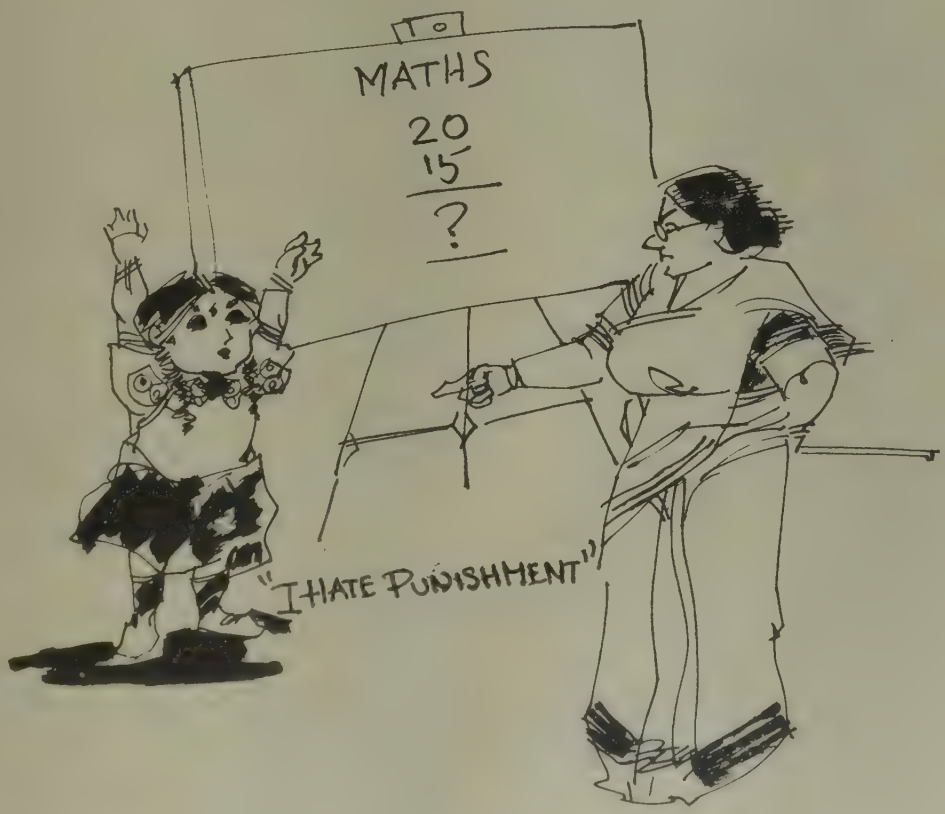
Although corporal punishment is an offence under the law, the rule is flouted with impunity, especially in municipal and small town schools, mean advantage being taken of the fact that most of the children there are drawn from the economically weaker sections-the parents' dissenting voices will be feeble and ineffective. There is no denying that teachers are a singularly harassed lot, taken for granted, often more underpaid than bank peons or restaurant waiters but that is again a problem area the government remains strangely unmoved to rectify.

Even the two-roomed schools promised under Operation Blackboard are a distant dream in many parts of the country where frustrated teachers scream themselves hoarse at one group of children to clear out of class and hang around somewhere outside to make place for the set who had been out the previous half-hour, to sit in.

According to NCERT surverys over the years, pure academics have always won over the child's creative and physical development. This, a report concluded, "is perhaps due to the compulsions of present-day society which tends to give priority to students' achievements in subjects for their career advancement". A pity, feels Shirin Darashaw, principal of Bombay's J B Petit High School. She recalls proudly showing off her school years ago to British educationist David Horsburgh (who, incidentally,worked among the villagers of Karnataka with his low-cost teaching aids and toys, even painting globes on matkas there). He was impressed by the various co-curricular activities she was happy to point out. "But how much of music and dance do you have up to the final year?" he asked. That, Darashaw concedes, was the bitter test. It is still unacceptable to the powers-that-be that such areas be looked on as regular "subjects", that there ought to be nothing "extra curricular" about them.

It is an altogether bleak situation. Until radical policy changes are implemented and — more — crucial — followed up with strong-arm measures, school education will stay etched where it is. On an unclean slate.

— *Courtesy Illustrated Weekly*



Let's talk health

Shashi Sunny

Every man, woman and child should have the right to lead a healthy life. For this they must be in a position to get adequate information on issues that influence their health, like the environment, water, food, good and bad habits.

During 1989, WHO and the Indian Government as well as other member countries found ways to drive home the message "Let's talk Health" by adopting a variety of means. For example, through children's plays that convince their parents about hygiene at home or a song explaining how malaria can be held at bay by draining a local swamp or media campaigns aimed at reducing the toll and injuries on the roads.

One successful experiment conducted with rural school children in India illustrated how a comic book became an effective tool for information on immunization, to village children and their parents. The idea was to use child-to-child and child-to-parent communication to carry the message that all children under 12 months of age should be immunized.

Children between eight and twelve years were to read the publication perhaps in class and take the message home to their parents.

To test this theory, a survey was conducted to discover the target audiences pre-knowledge of immunization and determine how much information should be included. It also assessed their visual literacy to determine their level of sophistication and select the most acceptable vehicle for the health messages.

Results showed that, given the right kind of comic book, rural children being naturally eager and curious would adapt to this new and interesting form of reading and take the message home to their parents. In this case the children became the agents of change — the communicators.

Since health information and health services go together, all levels of health staff have to be involved. In the villages of Maharashtra, the dais or traditional birth attendants were trained to conduct home deliveries using simple Dai's Delivery Kits. As a result, maternal mortality came down to near zero within two years, but more important each Dai became an effective channel of communication for health. Women in the villages listened to them and valued their health advice.

Women themselves constitute another large resource of health communicators. It is the women who tend to most people in the world, whether as workers in primary health care, in clinics, hospitals or more informally in homes as they care for the children, the sick and elderly. Yet the contribution they make to community health is often ignored.

It is all the more vital therefore that the level of education and health knowledge of women should be raised and that they should have more voice in decision making at every level of health work. Similarly, each school child should be taught not only the causes of illnesses and how they can be prevented and controlled, but also ways to promote health. They will then form the future network of health communicators.

An experiment conducted in Miraj in Rajasthan shows that helping small groups of people in the villages to form health committees to discuss health programmes, analyse the causes and develop strategies to tackle them, is one of promoting health awareness.

Making people aware of their rights and responsibilities helps them to determine their own health priorities and take part in solving their own problems. To achieve this all credible channels of communication including the traditional methods of story telling and drama and modern means like radio and television as well as the printed media have to be pressed into service.

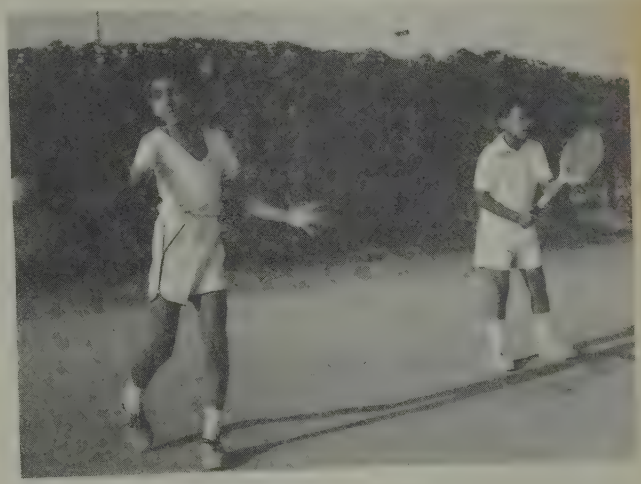
Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad 500 003. Ph: 841610

School Sports: Play It Safe!

Dodi Schultz

When the headlines announce the sudden collapse of a young athlete, parents of other youngsters are likely to worry — for a day or two, until it's evident that the incident was a rare kind of event (usually caused by extreme fatigue, dehydration, or an undetected heart condition). While it is highly unlikely that your child will come to great harm on the playing field, you should-well-not worry, exactly, but be concerned about the risks a teen or preteen faces upon getting involved in scholastic team sports. The concern should start before the youngster signs up, and it should continue.

Although the risk of sudden cardiac or other potentially lethal events is very low, the risk of injury is very high: In a study of organised high school sports, it was found that 20 to 40 percent of the participants are injured at least once during the school year. While most such injuries are not terribly serious in and of themselves, they can have quite serious consequences for youngsters.



Monitoring your child's growth

One reason is that kids of this age are still growing. As a professor of orthopedic surgery explains, "There is an area called the growth plate where the bones are still developing that constitutes a 'weak link'. Injury in this critical area could lead to permanent disability". Full growth is achieved, on the average, at about age fifteen in girls and seventeen in boys, but there is considerable variation from one individual to another.

"Basics should and must be checked," a paediatrician says "and of course, heart murmurs and other abnormalities are important to look for. Blood pressure should be determined. Special risk factors such as coagulation disorders and other chronic conditions must be taken into account".

Among key questions to which the physician should seek answers in counseling a youngster on going out for sports are:

★ What is the stage of physical maturity? (This is determined by physical examination and sometimes by X rays, which can be used to ascertain skeletal growth.)

★ Has there been a recent growth spurt? Contact sports may be especially risky at this stage, and a youngster may be advised to select swimming or tennis for now and postpone participation in football or basketball — assuming the school offers choices, which it should.

"In general", "the more rapid the rate of growth, the higher the susceptibility to injury involving the growth plate. Another significant thing is that as height changes quickly and limb bones become longer, there are problems with accommodation to these shifts-problems with eye-hand coordination, for example, and a certain amount of awkwardness. This, too, is going to increase susceptibility to injury".

★ Have there been any injuries in the past? If so, are they fully healed? Has any part of the body, such as a joint, been injured repeatedly? That could indicate a congenital weakness in that area, with the prospect of further damage.

★ Has the youngster ever felt faint, light-headed, or dizzy while exercising? (Such symptoms could reveal heart or circulatory problems or central nervous system disorders.)

The doctor adds that anyone for whom the possibility of injury poses a critical threat to life should, of course, be automatically excluded from competitive contact sports. That would include youngsters with coagulation disorders as well as those with a single normally paired organ (such as one kidney).

The mere presence of a chronic medical condition, on the other hand, need not exclude a child from sports — so long as those conditions have been diagnosed and are under careful control. "Many athletes, at both the school and professional levels," "have diseases such as diabetes or seizure disorders or asthma. As long as the conditions are recognized and appropriately controlled, these players do fine."

Assessing sports programmes:

Once your son's or daughter's participation in a particular sport receives a medical stamp of approval, say the physicians, it's a parent's responsibility to look into how that sport is run by the school. Are qualified, certified trainers in charge of the programmes? And is the equipment in a good state of repair? Many injuries are associated with improper or unsafe equipment, "It's up to parents to bring up this issue with people in charge of sports in the school. Be sure, too, that rules about wearing protective gear are strictly enforced. The same goes for rules specifically formulated to avoid serious injury, such as those against spearing in football." ("Spearing" is driving one's head directly into an opposing player.)

Another doctor points out that kids, as well as the equipment they'll use, ought to be in good shape before sports tryouts. "Adults in their twenties and thirties have become fitness conscious; a great many teenagers haven't. Study after study has shown that kids are far less physically fit than they should be."

For high-school athletes who are serious about joining a team, he recommends an individual programme that includes daily stretching routines, for flexibility; aerobic exercise four times a week; endurance-building activity, such as bike riding for an hour or two at a leisurely pace, twice a week; and muscle-building routines twice a week.

How about the makeup of the teams? Are kids grouped with other youngsters strictly on the basis of their ages? "Unfortunately, you will find schools setting up the "under-twelve foot ball team" or the "under-fourteen basketball team." With the tremendous variability in growth and maturation rates, this system makes very little sense. Not all fourteen-year-old boys — who may be very different in terms of muscle mass, growth rate, and stage of maturation — should compete against one another."

Coping with injuries

Another risk is posed by the fact that frequently, injuries are not properly handled by school authorities. In many cases, school sports are run much like adult sports, in a very structured, win-oriented manner. This leads to the most common orthopedic problem in kids' sports, the overuse syndrome — injuries, such as stress fractures of the leg and 'Little League elbow,' that result from demands exceeding capabilities. Youngsters are pushed to perform and keep performing, ignoring symptoms. This practice is extremely unhealthy.

Of course, both parents and school athletic officials must be aware of these concerns-and must insist that proper precautions be observed.This requires "good medical monitoring": knowledgeable supervision, alertness to injury, insistence that a child cease playing when there are signs of pain, discomfort, or any unexplained symptom. There should be medical evaluation, and a clean bill of health, before participation is resumed — even if no injury is apparent. Neither parent nor coach should put winning before the player's health. And if an injury has been sustained, a physician should determine that healing is complete, and everything is back to normal, before the child returns to the activity.

Sexist bias in school text books

The preface of Book I of the Primary Social Studies series used by the ICSE and CBSE schools in class I states that "the present series has been completely restructured and revised, in accordance with the NCERT syllabus, so as to develop the right social attitudes and values in a growing child. "It is obvious that the claim is only skin-deep and has no relevance with what has gone into the text.

In Lesson I a blatant statement is made, "mother cooks food for us" which is followed by a sketch of a woman sweating it out in the kitchen. In Lesson 6, an oblique reference is made to the father as Supremo, "Father is the head of the family. He earns for the family. He buys food, clothes and other things for us. He also gives us some pocket-money." So don't anger him kids, you may as well learn at the tender age of five-plus, which side your bread is buttered on. Nailing the coffin on the subjugated status of women is yet another black-and-white statement, "Mother works at home. She cooks for the family. She keeps the house clean and looks after our needs. She also does the shopping for the family." Sketch shows a woman in a housecoat mopping the floor. The background has a fridge, flower vase, curtains, cabinets. Obviously a well-kept upper middle-class home. Well, most upper middle-class homes, have maids to do the cleaning.

As a mild concession to libbers who may chance upon the text-book, these statements are followed by a palliative. "Some mothers also work outside the home. Some mothers are teachers. Some mothers are nurses or doctors. Some work in offices." This after-thought would hardly register for what has been dinned into impressionable minds in the main lesson is that their mothers are cooks and house-maids rolled into one. If she "also" happens to work outside the home, then its her bad luck. Her main job is that of cook-cum-house-maid.

In homes where both husband and wife work, house-work is shared by both of them. This is happening in most homes, where the couple are educated and well-informed of their rights. And as for sweeping, mopping and washing dishes, in most households — even-in lower middle-class homes, where the couple are both working — the daily help or maid takes care of them. On days when the maid does not turn up, the husband and wife take turns in getting the chores done.

This is not a fallacy, this change is taking place in many homes. Trishna a journalist, working shifts in a newspaper and her husband share the chores in the house. He bathes the children and gets them ready for school while she gets breakfast and while she is feeding them, he clears up the kitchen. His argument is "this way I get more time with my wife."

Rani who works in a bank returns home in the evening to find tea ready and dinner half-way through. Her husband gets home earlier than her and starts dinner. He says, "Once that is done, we have the whole evening free to go out or spend it with our child."

Veena also works in a bank and has a husband who comes in very late from work. But he shares the work in the kitchen every morning. He gets breakfast while she gets her son ready for school. He reasons out, "actually I cook better than her... but seriously, I know she can't cope, there is so much to do. Anyway she has to manage on her own in the evenings."

As for the other statement in the text-book, of the father being head of the family and earning money for the family, this is not completely true. In homes of working couples, both contribute equally towards the family expenditure. In fact in Sita's house, her salary comes in on the first of every month, so she takes care of groceries, pays the milkman, maid and school fees. Her husband's salary goes for the house-rent and the family savings.

Probably the NCERT has not realised that times are changing or even if they are not, as educationists, it is their duty to feed the right ideas in children. In homes, where right-thinking adults are trying to inculcate the right ideas into young minds, such school-books ensure a state of confusion in the impressionable minds. They are taught a different set of values at home and another at school.

Notwithstanding the sexist bias of school-books, we have a media blitz by advertisers, asserting the role of a woman. We see her singing the praises of a fairness cream or extolling the virtues of a detergent. How about the aggressive ad campaign by reputed banks in the print media. The reader is asked to save for the education of his son and a good marriage for his daughter.

What is ironical is that these banks have almost 50 per cent of their workforce comprising women. These women have had to sit for competitive exams along with their male counterparts and have been selected for the job purely on merit. Many parents have begun to realise the need to educate a daughter that she may find a good job. These are times of tight financial resources and, it is essential that a woman works to help support the family. Aren't these banks doing a gross injustice to their women employees by compartmentalising their role in their ads.

A report in "THE HINDU" says that "there has been a gradual but significant increase in the number of girls getting admission into professional courses like engineering, medicine and dental surgery." The report goes on to add, "The girls to boys ratio which was about 1:4 in the Sixties, has shot up to around 4:1."

This again proves that education is given precedence over a good marriage by many parents now while deciding their daughter's future. More and more parents, especially women are becoming aware of their rights, or more importantly the rights of their children.

In far-away Zambia, Anna Lumbwe, a house-maid is determined that her six children remain in school. Her husband who is a cook manages to support the family. "I am very particular about the education of my daughters. I don't want them to be like me with no education," she says. "I want them to be able to get good jobs and support themselves and help the family." she adds, "They must have a better life than they have now." Anna Lumbwe was one of the many mothers interviewed by a foreign service after fees were re-introduced in schools by the Kenneth Kaunda government.

It is time the NCERT and banking institutions shake the cobwebs off their collective heads and see the changes taking place all around them. A sati here or a dowry death there does not make a summer, there are many brave ones out there who have wrought a change in their lives and would like their children's lives to be different too. So why don't we help them?

How the Book (worm) turns

Sanjay G

TEACHER PLUS made a survey that was conducted among teachers by **Geetha Rao** and among students by **Sanjay G.** We hope that the analysis and the results of these two surveys which are fairly representative are useful. The teacher's survey was conducted in Madras and Hyderabad, and the students survey in Hyderabad among a cross-section of school children aged between 10-15 years. We found that teachers do not find as much time to read as they would like to, or should, and that very few teachers are reading serious subject-oriented material. From the students' survey, we found that children are doing a lot of unguided reading and are reading almost anything they can lay their hands on.

Sampling Student Tastes

During my summer holidays in May I was asked by Orient Longman to do a survey of the reading habits of children. I was asked to make a questionnaire. I wrote down as many questions in rough that I could think of. I marked out the ones I wanted and then with the help of Arvind from Orient Longman arranged and reworded the questions for the questionnaire. I found out how difficult it is setting a questionnaire since Arvind told me that if there was very little writing more people would finish the questionnaire. I had to frame the questions so that the answer could be a yes or no or a number. This would make it easier for the children who were going to answer it. I realised that making out a questionnaire was not all that simple.

In summer I went swimming at the Secunderabad Club. Many other children also came there to swim. I got as many children as I could to answer my questionnaire. The older children had little problem in understanding the questions. The younger ones needed help, so I sat with them and helped them do it. I was able to finish quite a few at the Club. I had decided to do about a 100 questionnaires. I was not able to finish all of it in the Club. When school reopened I got the children in my school to do the questionnaire also.

After I got all the questionnaires back I had to sit down and total up all the "yeses" and "nos" according to each age group. For each age group I took a big sheet of paper and made horizontal columns for each question and wrote the choices under each question. Then I started counting. I took each questionnaire and made marks for each question on the big sheet (of that age group) under the answer.

These answers were fed into the computer at OL. The graphs made by the computer give a good idea of the results of my survey.

How children choose books

The kind of books children read

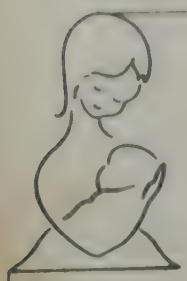
It was interesting to see how children choose the books they read. From the results I found that adventure/mystery was the favourite of all ages from 10-15.

Most children did all their reading in English. Very few children were reading books in Telugu and Hindi. I found that most children do not read every day. They usually read once/twice a week. Though many said they read everyday, I think children are not able to read everyday because they have a lot of lessons to study. More children preferred reading books to watching TV though quite a large number opted for watching TV as the best way to spend spare time.

Frequency in reading books

I also found that children read a variety of books- Enid Blyton, Nancy Drew and Hardy Boys mysteries, etc. Just now I am reading a lot of Roald Dahl and I was happy to see a few others mentioning him as their favourite author. Many others had mentioned Gerald Durrel as their favourite author. The most popular books were:

1 David Copperfield
2 My family and other Animals
3 Adventure of Sherlock Holmes



The most popular authors were:

1 Charles Dickens
2 Gerald Durrel
3 Enid Blyton and Arthur Conan Doyle.

But many authors and many books, many not known to me-were mentioned.

I enjoyed doing this survey though putting the results together was not as easy as I thought — it took a lot of time!

Were teachers aware of what their students read? A majority (54%) agreed on adventures and comics topping the reading list of children.

And children that joke books and books on sports came third and fourth respectively.

Some of the answers to the question, "What kind of books do you feel ought to be published for children ?" were the following:

★ books on science

★ books with morals, inculcating noble qualities, civic sense

★ books on great personalities, culture, heritage, art

★ abridged versions of classics

★ books that helped students become creative, solve problems on their own, make them more independent

★ books with colour and illustrations

★ books that inculcate national character, patriotism, scientific approach, progressive ideas and open-mindedness.

— *Courtesy: TEACHER PLUS*

The best sign of healthy growth in a child is fearless questioning and satisfying answers

Television and the Indian Child

My four year old daughter was humming while she was playing. I listened and asked her to say it loud. It turned out to be the T.V. advertisement....."Washing powder Nirma...."

While watching the English news the other day I came to know that incidences of eye injury is on the rise. Well, the cause was children playing with bow and arrow. Doctors were not sure whether the eye could be saved or not. Why was there a rise in incidence of eye injuries? According to experts it is all because of "Ramayan" and "Mahabharath".

A few years back Delhi Doordarshan had screened "Living Planet". The time of telecast was late night. The programme was interesting and informative. On popular demand from Delhi children it was screened again.

It was a fine Sunday evening. After having a relaxed afternoon nap and enjoying cup of tea, our eyes suddenly went to the big watch ticking in the living room. Oh! It was already 5.15 p.m. On immediate reflex, I switched on our T.V set. All family members crowded before the Idiot box to see what ?..... "Micky and Donald" and for the next half an hour enjoyed immensly the hilarious animation film.

T.V. influences

There could be numerous examples how television has influenced us — specially children. Children are the main clientele of television anywhere in the world. Research indicates that attraction is equally valid for urban as well as rural children, for school going children and drop outs, for preschoolers and for older children. Often children are the motivating factor in persuading parents and village elders to buy television.

Today many media researchers accept that regular T.V. viewing starts around age of three. Viewing time increases as the child grows older, reaches its peak in early adolescence and then decreases towards the later period of adolescence. As adolescents approach adulthood they come back to T.V. The desire to escape from everyday life during late childhood and early adolescence and the desire to know real life later during adulthood are said to explain this viewing behaviour.

Media considerably influences children and the masses and can often be effectively used to achieve the desired effect. The potential of television for education and social development of children has been widely recognised. Evidence accumulated from studies conducted in many countries suggests that television can exert considerable influence on the lives of children and can inculcate positive attitudes, values and behaviour among children.

Preconceived notions:

Today parents in particular and people in general have preconceived notions on the beneficial or harmful effects of television on children. Parents appreciate this medium because it broadens their children's horizon and keeps them indoors "out of mischief", while on the other hand they have misgivings about what they see as its numerous harmful effects. There has been a great deal of public speculation that —

1. Television cuts into the time of children's school work and serious study and ultimately affects their academic performance.
2. Once addicted to this medium children become listless, leading to passivity and poor concentration in other spheres.
3. Some of the programmes such as imported serials which glorify violence can lead to aggression, or create hallucination in the children's mind.
4. Television is bound to create displacements in children's schedule of daily activities in order to make room for viewing programmes.
5. Television has a dominating influence on general family life, and this can cause conflict, often parents feel they are loosing control and have no authority over their children.
6. Constant watching of television, specially in colour may damage the eyes.
7. Television viewing may lead to a reduction of interest in sports, extra curricular activities and social contact.

No harmful effect:

Keeping in view some of the speculation, studies have indicated that with the present limited transmission T.V. has had no visible or apparent harmful effects on children. Children spend a large part of their evenings on certain days viewing television but they are definitely selective about it. They are critical and seldom view the entire transmission from beginning to end. Television does not really interfere with their homework or cut into their studies, playtime, extra curricular and social activities.

Play to them is an enjoyable activity as it provides an opportunity to meet friends from the peer group, away from home. Hence children skillfully adjust their other activities in order to watch their favourite programmes. "fantasy" and "exciting action" are the two main ingredients which make the programme popular with children. Feature films, dances and songs, adventures, thrillers are popular among children because of the child's need for a sense of indentification with the character.

Advertisements seem to have a marked impact and the ability of children to recall them in detail is extremely significant. Captivating words, phrases and colourful visuals stay in their memory.

Feature films may be popular because they provide "excitement" and "action" which is important for holding children's attention. They take children to a world of fantasy and provide a glimpse of adult life. While films with aggressive themes offer vicarious experiences those with romantic themes appeal to them because of adult emotions and sentiments. Emotionally disturbed children tend to see the "hero" as a "god" like figure on whom they can emotionally rely, whereas more stable children identify themselves with the hero in experiencing heroism and adventure. Children also appreciate

films which depict breaking of the shackles of convention by which they feel bound.

Children's programmes

The study showed that programmes specially prepared for children are not very popular. The reason for this may be the absence of fantasy and excitement. The viewing behaviour of children indicate that they hardly watch informational, educational, or developmental programmes as they are based on discussion and lack elements of fantasy. This view is supported by the fact that the educational programmes that are entertaining like "Quiz programme" and science serials like "Startrek" and "Giant Robot" arouse the curiosity of children and are popular among them.

Work in Indian television for children went on without much serious research effort whereas media researchers abroad made geniune studies towards understanding children's television viewing behaviour. The only research based T.V. production for Indian children in age group 5 to 12 years started with "Satellite Instructional Television Experiment" (SITE, 1975-76)

The programmes were produced mainly with the objective of helping children to learn community living skills, instilling habits of hygiene and healthy living, promoting aesthetic sensitivity, and making children aware of the entire process of the modernisation of life and society around them. In addition science education programmes were aimed at making children realise that science is everywhere, that their immediate environment can be questioned by them, understood, explained and manipulated by them, using the scientific method.

Positive effect:

Available evidence showed that when children are exposed to such programmes it has a positive effect in many spheres. Children accepted and appreciated such programmes. Younger school children showed more curiosity especially in general science after watching television. The thinking of children underwent a change. Earlier they felt that science was learnt at school, but after the SITE experiment they felt that they can learn it anywhere. After viewing, the general understanding and information seeking behaviour changed. This view is supported by the fact that children were more keen to read and find further information. The health and nutrition programmes also had a positive effect on school children. Children learnt to bathe and keep their surroundings clean.

Other effects of the SITE experiment showed gains in cognitive development and language development.

Hence it can be concluded that a powerful medium like television can help our children in many ways. What is required is organised planning and understanding growing children's need. Television can be used effectively for overall development of the child that is — physical, social, emotional and intellectual development. Every aspect has a positive and negative side. Nothing can be perfect, so is the case of T.V. Children may imitate "fantasy" and "exciting action" in their play. There could be some harmful effects like increase in eye injuries etc. as mentioned earlier. But all this can be eliminated if programmes are produced in a better way — that is realising children's needs and considering the possible impact. If more meaningful programmes are produced, our children could be benefited in a better way.

Good deed:

Three small boys told their Scoutmaster that they had done their "good deed" for that day.

"Well boys, what did you do?" asked the Scoutmaster.

"We helped an old lady across the street a little while ago," they all said in unison.

"And did it take all three of you to do that?" asked the Scoutmaster suspiciously.

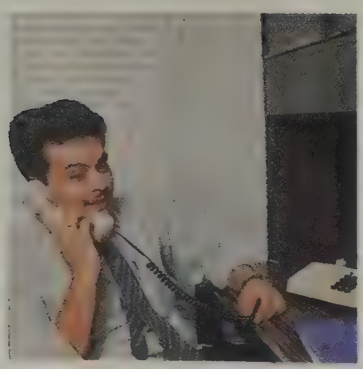
"Yes it did," chorused the boys.

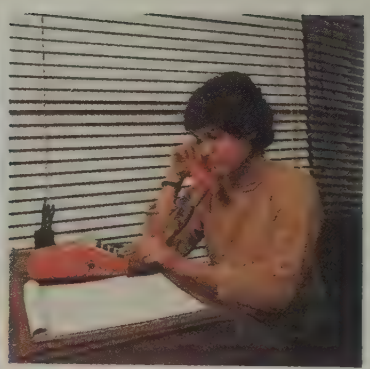
Then the smallest one added, "You see, she didn't want to go!"

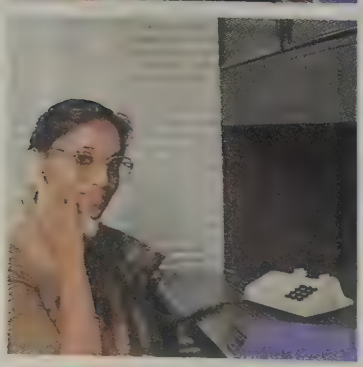
Stallion II

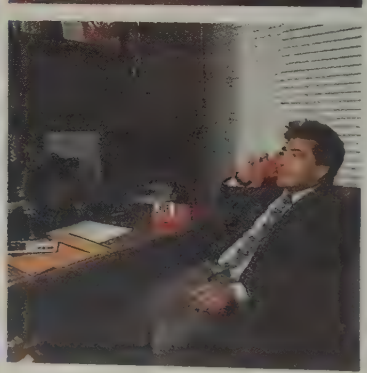
DIGITAL

EPABX SYSTEM.









THE TUSKER 500
ELECTRONIC TELEPRINTER SERIES.

HCL LIMITED (COMMUNICATIONS DIVISION)

HEAD OFFICE: 601, Siddharth, 96, Nehru Place, NEW DELHI-110 019. Tel.: 6431291/6447990. Tlx.: 031-62544 HCL IN, 031-65705 HXL IN. ■ 43 Deepak Building, 13 Nehru Place, NEW DELHI-110 019. Tel.: 6431294/6444306/6413970. ■ Aarohi Block No. 2, Kapoorthala Complex, 2nd Floor, Aliganj Scheme, LUCKNOW-226 001. Tel.: 78146/78158. ■ 45/46 Shastri Nagar, Katewa Chambers, Near Pital Factory, JAIPUR-302 001. Tel.: 73028. ■ SCC 66-67, Sec. 17A, CHANDIGARH-160 017. Tel.: 41961. ■ 5th Floor, Saraf Chambers, Mount Road, NAGPUR-440 001. Tel.: 24527. Tlx.: 715-441 MAHD IN. ■ 74, Regent Chambers, 7th Floor, Nariman Point, BOMBAY-400 021. Tel.: 2040437/2872307/240888/ 232764 Tlx.: 011-2232 HRL IN. ■ 3rd Floor, Shalin, Ashram Road, Near Nehru Bridge, AHMEDABAD-380 009. Tel.: 76467/77800/77216, Tlx.: 0121-6829 HCL IN. ■ 201-208, Akhsay Complex, 2nd Floor, Dhohpatil Road, PUNE-411 001. Tel.: 661406. Tlx.: 0145-613 HCL IN. ■ Rajgaria Mansion, 11/1-A, Sarojini Naidu, CALCUTTA-700 017. Tel.: 447714/448651, Tlx.: 021-2974 COMP-IN. ■ Jayalakshmi Estates, 8 Haddows Road, MADRAS-600 006. Tel.: 476846/474633. Tlx.: 041-6433 SOFT IN. ■ 319 & 320, 3rd Floor, Chenoy Estate, Trade Centre, 116, Park Lane, SECUNDERABAD-500 003. Tel.: 831390. Tlx.: 0425-6871 HCL IN. ■ 54, St. Mark Road, 4th Floor, Laxmi Complex, BANGALORE-560 001. Tel.: 568145/573217/573526. Tlx.: 0845-2180 HCLB IN. ■ UR House, 1056-C, Avanashi Road, COIMBATORE-641 018. Tel.: 23619/30091. ■ 4th Floor, Srinivas Chambers, 38/867, Mahatma Gandhi Road, COCHIN-682 035. Tel.: 361746.

COMMUNICATIONS DIVISION

HCL LIMITED

The Idiot Box

Dr A K Vasudevan

When I was asked to write on the television, I wondered what I would write. I asked the children to write, but they wriggled out of it. I looked up some books on the subject, but could get nothing on it. Finally I went around asking people what television meant to them and their children. Here are some excerpts:-

"Thank God, Hyderabad Doordarshan has only one channel. Programmes are shallow and anything worth watching is shown only late in the night," said one neighbour.

"Television has encouraged violence," said another. "My husband and children are always quarrelling all the time about what to watch, and I feel like bashing it up," she added.

"T.V. has come to stay," said the friend from across the street. It is a powerful medium and a perfect brainwashing machine. And powers-that-be know its usefulness," he said.

His wife put in her mite. "It is an excellent baby-sitter and a very economical one. My two-year old kid is hooked onto TV. Any programme would do."

"My kids go to bed late and are late to rise, nay they have to be pulled out of bed and pushed into their school uniform," lamented my wife's friend.

"The art of conversation has disappeared. Never visit anyone while a feature is on. Only a cold reception awaits you," said the avid socialite.

"Homework is not done in time or is shabbily done. The children's performance in examinations are affected," said another parent.

"Have you noticed, they don't even take an interest in games. They can't even spin a top," he added.

"My children appear tired and irritable after a few hours of TV viewing," said a mother of two. "My son is restless after the programme is over. Could it be a withdrawal symptom?" she queried.

"Mealtime was a pleasant family affair before the advent of TV," said a grandfather. "Now its only TV dinners. And the ads on TV entice us to consume many products that we really don't need," he added.

This lady put it succinctly, "This is nothing but mass hypnotism. I feel guilty, but can't help myself. I guess I am hooked."

Now that I had got the views of friends, neighbours and others, I decided to poke around for comments from my colleagues in the medical profession. One doctor, lamented that his practice was dull on week-ends, as his prospective patients were too busy watching TV. Another doctor said that TV should be watched only for half an hour, lest it damages the eyes .

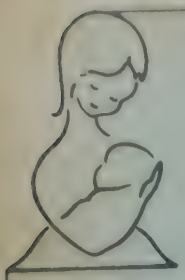
A neurologist said it could cause photic epilepsy.

The myriad reactions were an eye-opener. But one strain was very evident in every reaction, that television was an addiction and one could get hooked onto it. As Indians we should be proud of our family system of living and television seems to be eroding this, slowly but surely. Let us control it before it controls us. If you have the guts, drown it in the Hussain Sagar, or if you don't want to do anything that drastic, pack it off to the attic, like me and use it only for special occasions.

TV is making us passive onlookers and steering us away from action. Let us become doers and not dreamers. Let us wake up from our TV induced stupor and stay sharp. Let us break away from television's addiction and de-addict ourselves.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad - 500 003. Ph: 841610

Midnight's Children



THE CHILD

Rev. G T Vadakel

— Thou child of man, masterpiece sublime
of artist, creator and lover above;
Thou seat of beauty, of wonder and love,
Thee I salute in words set in simple rime.

— Thou face all angelic, thou look so pure
Thy smile so winning as ever demure,
Thou fruit of love, thou crown of creation
Thee I marvel at daily contemplation.

— This little something, God's incarnation
This crying cherub, this seraph lisping,
This seed of greatness, a hero in the making
Thee I consider beyond all narration.

— Thou bambine bachcha, thy form a balm for all
Thou syllable sacred and serenity's symbol,
Thou father of the man, abode of God so humble
Heart's delight thou hold the world in awe and thrall.

— But what transformation, thy look so forlorn
What degradation, thy comeliness all gone !
Gored is thy visage, ravished thy innocence,
Formed in God's likeness, now deprivation's semblance!

— Once robed in splendour, thou innocence embodied
Thou creation's diadem now trodden and sullied,
Ah me! man's making, cruelty sans par
This holy of holies to desecrate and mar.

— Greed's handiwork, thy lean and hungry look
Absence of love that's seen at every nook
So thee I espy all in sobs and in tears,
'Shame' though I shout, my voice no one hears.

— Thou hapless babe in need of food and warmth
Man set thee out with a begging bowl in hand,
Thou wanting home and loving-care in strife,
Who orphaned thee on the path of real life?

— Oh fall on thy knees, man so brutish turned
For making God's masterpiece a caricature burned
Restore the form divine, and shattered image redeem!
This plight of the child, a sacrilege I deem.

— But lo! the scene changes, for the battered and bound,
The Campaign for the Rights of the Child is around,
If human is back again, can brutal hold sway?
If liberator is nigh, can freedom be (far) away?

Where flowers are crushed for their fragrance!

Patricia Palaparti

The children's Charter by Dorothy Roight says:

"There shall be peace on earth; but not until each child shall daily eat his fill; go warmly clad against the winter wind and learn his lessons with a tranquil mind... And thus released from hunger, fear and need, regardless of his color, race or creed, look upwards, smiling to the skies, HIS FAITH IN MAN REFLECTED IN HIS EYES".

The questioning look is a far cry from the look of faith in his world of adults!

"Crushed am I, crushed must I remain?"

How well has man kept FAITH with the child? More importantly, how well has the Indian man kept faith with the child?

Today, in India, technology and science march, nay, gallop towards the 21st century and man seems to have kept faith with himself — to achieve the almost unachievable in spheres of life that seem important to him.

And yet, yet there are still millions of children today who keep picking through the garbage dumps, scavenging for bits of food or sorting out what's usable; we still have little boys not even eight years old working an 18-hour day washing utensils in the restaurants and bars; we still use children to scrub and clean our homes while our over-fed, well dressed children go to school or sprawl around watching television.

How many of us stop to think that the glasses we drink from, the matches we use, the beedies we smoke, the bangles we wear, the carpets we trod, the embroidery we flaunt, the slates we write on — and so much more — are all produced by tiny hands — hands that should be playing, writing, reaching out in pure undiluted, unencumbered joy?!!

We are aiders and abbettors in this crime against children. It is only when you stop to look that you realize you find child labour everywhere — and what do we do? Turn and look the other way! But even the other way will present a working child to your gaze... there is no escape if you have a conscience.

If in the rural areas 90% of our children work in agricultural and related occupations, in our urban areas the remaining 10% work as domestic servants, in hotels, at construction sites, workshops and automobile repair and fuelling stations etc. etc. Our children need to work to stay live! This is the sad, stark reality of our lives. Our children still look up with faith and hope — if we don't do something to ban and eradicate childlabour, the hope in the child's eyes will die. And the child cannot wait...

We need to find some answers now, today — inspite of the hurdles in our political, economic and social systems. The child needs to work because of unequal distribution of wealth resulting in chronic poverty — the child works because of a lack of faith in the existing education system, if a child goes to school there is no guarantee of a job at the end of it.

The wheel of time does nothing to influence her wheel of fortune. Our children need to work to stay alive !

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad–500 003. Ph: 841610

Yet another cause of child labour is home-based or family occupations.

Child labour assumes the character of a social problem in as much as it hinders, arrests or distorts the natural growth processes and prevents the child from attaining full blown adulthood.

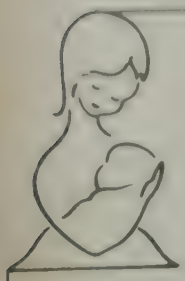
Consider: Children are kidnapped, tortured and forced to work in sub-human conditions in the carpet industry of Mirzapur. A survey ordered by the Supreme Court found that 41% of carpet weavers in UP are under the age of 14 and 48% of these received no wages, only food. The rest got Rs. 1 to Rs. 5 per day. The kind of work they do causes eye problems, skin problems, filaria, asthma, TB, enlarged lymph glands. According to reports, the carpet production might fall by 50% if children were not employed, and India would not be able to compete in the international market!!.

Consider: The diamond cutting units of Surat employing about 2 lakh workers of whom 15 are children. The children learn the skill after a few months of rigorous training. They live and work in squalid ill-ventilated factory premises for 12-15 hours a day. Eye strain, headache and T.B, skin diseases, viral and urinary infections are their reward. The pittance they ekk out is an average daily earning Rs. 15/-

Consider: Almost the entire production of matches in Sivakasi is non-mechanical. 50,000 children below 15 years of age work here. Between 3 am and 5 am every morning children are woken up in the surrounding villages and loaded into buses — over 200 packed into a single bus and taken to the factories. Between 6 p.m. and 9 p.m. they are returned to their houses. Though they work only 12 hours they are away from home for 15–16 hours a day. Most children are below 7 years of age — girls outnumber boys 3 to 1. They fill frames, make boxes, count, paste labels. In the fireworks industry they dye paper, make crackers and pack the final product. Children who stamp frames suffer from heart, toxic fumes and excessive strain on the arms and shoulders — delay of a second can cause th entire frame to go up in flames which causes instant death. The working conditions are detrimental to mental and physical health. They earn Rs. 2 to Rs. 7 per day.

Consider: The balloon factories where children work with a thick pall of dust and chemicals filling

Child labour assumes the character of a social problem — hinders, arrests and distorts the growth process !



the small ill-ventilated rooms. They work nine hours a day — their reward is pneumonia, breathlessness, heart failure.

Consider: The lock industry or the Glass Bangle factories of Aligarh where 10,000 children work the hand presses on buffing machines, polishing rusted metal pieces in electroplating workshops and in spray painting units. Most of them suffer from TB, asthma, breathlessness and acute headaches.

Consider: In the unrelenting heat of the Glass Bangle factories of Ferozabad, children carry molten glass to the oven for threading. The work requires speed and care — a small mistake will mean severe burn injuries and no work or pay till the child can come back fit for work — no medical expenses... Being exposed to 1300 degrees Celsius heat everyday can lead to cancer — it can also result in anaemia, retardation of growth, muscle cramps, respiratory ailments. Today, 40,000 children below 14 years of age work in these factories. The children earn Rs. 9 to 16/- a day and are forced to work overtime without extra pay. It takes only 3 or 4 years to destroy their lungs. Their life-span is reduced to one third!

Consider: The children who work at powerlooms — the cotton dust causes fibrosis of the tissues in the lungs — there are 15,000 children working in the powerloom industry of Bhiwandi in Maharashtra.

Consider: The slate industry — Cutting slates gives the children a lung disease much deadlier than Tuberculosis. Children at the age of 12 or even less are forced into this fatal work to sustain their dying parents — only to learn that they too will die soon enough... Most of these workers choke to death.

Consider: Children working in dhabas and as domestic servants — they live mostly on footpaths or employer's premises — always at the mercy of the customers or employers.

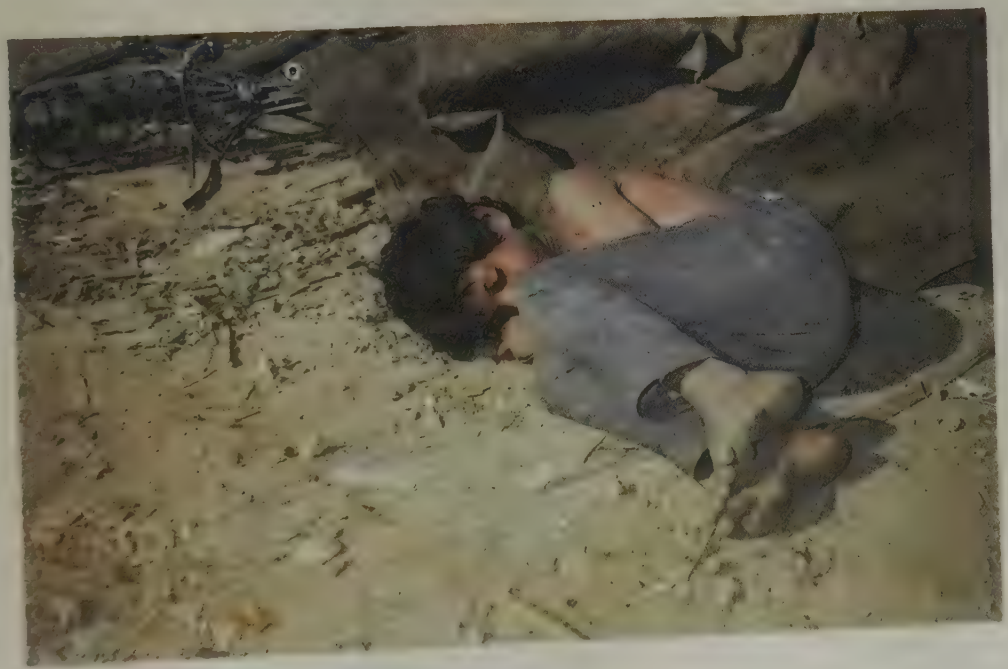
Consider: Children sexually abused and also used as pimps and drug pushers to the underworld of gangsters and thugs.

Consider: Organised beggary where innocent children are tortured and mutilated, sent out to beg and sentenced to a life of utter degradation and self denial. In old Delhi, Jama Masjid, Chandni Chowk, Ghanta Ghar and Paharganj there are children who, ruled by adults, are raped and sodomised and left in the grip of disease, drugs and death...

Consider: Human child and animal! Forced to forage for food from the same garbage dump! Are we too blind to see?

'How much do we ignore?'

And also consider: Each one of us, as we tuck our pyjama-clad little ones inbetween clean white sheets, consider, only consider: How much of child labour and abuse do we see ? How much do we ignore ? How much do we perpetuate ? How much do we shrug off ? And finally how much do we work at, to make this world a place where instead of being crushed to provide fragrance, the flowers of our future are given love, shelter, protection, caring and laughter? It's no pipe dream — the eradication of child labour! Every heart, hand and home counts for our children. Make a start. Today. Now!



With the sky as roof and a winter wind as sheets for cover, who will tell this child his bedtime story — or give him his goodnight kiss?

The Significance of the Declaration

The Declaration of the Rights of the Child is not a mere "scrap of paper", even though the rights it extols are not yet available to all — or even, unfortunately, to most — children. The universal recognition that these rights exist is a very important first step in achieving them, and the fact that so many countries, of such diverse social conditions and cultural traditions, have agreed on the importance of these basic principles is an extremely encouraging omen of future progress.

Ancient, deep-rooted social problems and injustices die hard. There is an inevitable time lag between the recognition and acknowledgement of obligations and the ability to carry them out. But the unique value of every human being, even of the smallest and most helpless, is now officially acknowledged by almost every government in the world. All over the world it is now agreed that children need and deserve special assistance, and energetic efforts are being made to give this to them.

These efforts are, moreover, recognized as a duty of good government, not as an optional luxury.

In the modern world, with its highly developed technology that makes possible destruction (and construction) on an unprecedented scale, peace is no longer a luxury either but an increasingly urgent necessity. Children must be helped to enjoy the right to grow up healthy (physically, mentally, morally, spiritually and socially, in freedom and dignity, as Right 2 of the Declaration asserts). If not, they will never be able — or willing — to join together in helping to build a better world tomorrow, a safer and happier and more peaceful world, in which their children can enjoy their "rights".

When we protect and foster the rights of every child everywhere, we are protecting and fostering everyone's happiness and everyone's peace, including our own.

The UN General Assembly unanimously adopted the convention for the Rights of the Child on November 20, 1989.

When will this child — and millions of others like him be given their rights ?

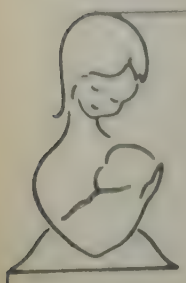
Value of children

The study shows that contrary to existing perceptions, the actual labour contribution of children, both in terms of time inputs and income, is nominal.

The study examines the structure of demand for children through positive and negative values attached to children. Data for the study was obtained from a sample survey conducted in Warda and Bhiwandi blocks of Maharashtra. Information was collected separately from 1,692 currently married women (aged 15-44 years) and their husbands.

Labour contribution

A number of time-use studies among less developed countries have observed that children do contribute substantial inputs of labour to the



household economy. The evidence from this study does not offer support for this finding.

The study shows that while a majority of the children (60%) do provide labour inputs to the household, the amount of time spent by an average child in this activity is limited to about two to three months a year.

Apart from limited inputs in terms of time, for the bulk of children, 'work' is in the form of non-earning activities such as housework or on the family fields. The results show that only 7-9 percent of 2,741 children (aged 5 to 21 years) are engaged in the earning activities.

The contribution of girls is in house work and the overall time input is greater among girls. At the ages 5-9, girls input is 79% higher than that of their brothers.

Motives for wanting children

The reasons for wanting a son were old age security, labour contribution in the house and field, and continuing the family line. Of these, the first two reasons are economic in nature.

The pattern for wanting daughters is quite different from the pattern for sons. Far fewer motives for having daughters have been expressed at all. The only economic motive for having daughters is their contribution in housework.

The results overwhelmingly imply the dominance of economic motives for having children (50 percent for sons and 55 percent for daughters).

Children, especially sons, remain the predominant source of financial support in old age. As many as 87 percent of all women and 76 percent of their husbands intend to rely on children for old age support. The results imply that as alternative means of support such as savings, pension, etc. become available, the reliance on children diminishes.

The results show that as education, income and mass media exposure increases, old age dependance on children decreases. The economic motives for having children were more strongly felt by women compared with men, and among lesser educated and lower income respondents.

Policy implications

The results offer no support for the argument that the labour contribution of children to household economy is substantial. They suggest that efforts to lower demand, for children may well dispel the popular notion that children are economic assets. The old age security motive is a powerful obstacle in the reduction of demand for children. Policies which aim to raise the economic self-reliance of parents, such as social security benefits and savings programme may provide a viable alternative to children as old age support.

Parity related security plans would offer further incentive for family size limitation.

The evidence suggests that such elements of the family planning programme as diffusion of knowledge of contraceptive methods play a lesser role in acceptance of contraception and fertility. Other factors such as age at marriage continue to play a powerful role in the determination of fertility.

This study suggests the importance of a third set of factors, i.e. demand for children.

It is clear that education and mass media exposure operate forcefully on demand for children. The effect of education operates independent of other socio-economic factors affecting fertility. The emphasis on education may have an effect on fertility in the absence of economic changes. From an immediate policy perspective, this points to a need to strengthen programmes for non-formal education.

Notably, three aspects need emphasis: that old age security alternatives do exist; that children are not helpful to the household economy as commonly believed; and that too many children constitute an economic burden.

Source:

Demand for Children and Reproduction Motivation: Empirical Observations from Rural Maharashtra

by Shireen J. Jeejeebhoy, FPAI and Sumati Kulkarni. IIPS,1988.

They are also human

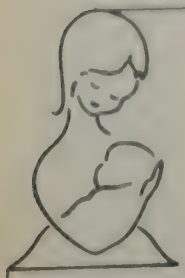
The United Nations General Assembly declared the year 1987 as the International Year of Shelter for the Homeless. Every country, including India, avowed its resolve to solve the problem. What has been done during the International Year and subsequently is anybody's guess.

Many of the countries built many houses. But, who were the people who benefitted ? Those who did not possess a house of their own and had lived in rented buildings were often the beneficiaries. Beyond the vast multitude of such families that do not own dwelling quarters, are miilions of people who do not have, and who cannot even hire a hut to retire to for a rest.

It should be remembered that no government in any country can provide shelter to all the people. Voluntary organisations have to step in to fill the breach. It is estimated that roughly one quarter of the world's population does not have adequate shelter and that they live in unhealthy conditions. It is also estimated that some 100 millions have no shelter at all.

They sleep on the pavements. On railway platforms, at bus stations, under bridges, in parks, in vacant lots and even in doorways. Perhaps, accurate data regarding the number of such shelterless people in our country and even in our State may not be readily available. It is difficult to enumerate them as they, often, keep moving from one place to another.

The rapid and accelerating process of urbanisation is often haphazard and chaotic. Homeless migrants who move to the towns tend to occupy land on the



periphery and establish slums, with the aid of politicians and land grabbers. There are also people who cannot afford even to live in slums. They do not have the wherewithhal to pay rents to those who erect the huts; netas who parade as the champions of the down-trodden. Grossly insufficient and degraded as the shelter in slums are, even that is beyond the reach of many. Children abandoned by their parents or who run away from their families for various reasons — conflict with parents, ill-treatment by family members, the lure of the city, etc —find it extremely difficult to live in the slums. They eat off the garbage bins, into which the left-overs from hotels are thrown.

One should consider the health effects on such shelterless people. Because of malnutrition and under-nourishment, because of eating contaminated food; the shelterless people quickly fall sick. Their body's resistance to disease decreases. With personal hygiene and habits contributing to their poor health, such persons pose problems to others. Often they are the carriers of contagious diseases. The society should, therefore, be as much concerned with this section as it is about the dwellers of the slum, for whom there are many champions and schemes.

Governments may come and go. The lives of these unfortunate beings continue on the same pattern. They have no vote and, therefore, the politicians have no need to woo them, except when they are wanted to accompany some groups and shout slogans — zindabad this person or murdabad that person. They have no voice and hence they do not agitate. Therefore, the governments are also not bothered about them. They have no other go than to take to the streets —begging, picking rags, collecting waste paper, broken pieces of glass, plastic and the like. The environment in which they live, the friends they make are all such that they easily turn into delinquents. The street children are, indeed, exposed to such dangers.

They are regarded as dangerous, a section of society that deserves to be despised. They are shunned and treated as if they just do not exist. People forget that they are also human and that it is only because of force of circumstances that they are forced to live on the streets. Most of them are not hopeful about their future. It is bleak. Will they ever get a chance to contribute to the country's growth ?

Having either been abandoned by the parents or having run away from their homes, the street children have little chance to develop their talents. They have almost no opportunity to secure education. When the children become adolescents, more problems arise. In their bid to satisfy their physical and biological needs, they take to crime. When the street child happens to be a girl, her problems are myriad. Unwanted by others, these street children, however, are "wanted" by the police whenever they have to show that they are active and are able to book criminals. The street children come handy and are paraded as criminals and even witnesses are produced to testify that they were, indeed, those who committed the crime-even if the children happened to be nowhere near the scene of crime! Made to live in the midst of criminals, the children imbibe their ways and become misfits.

Should not these children also be taken care of? Neglected by the parents, neglected by the Government, to whom should they turn for succour? Should they not be provided atleast a roof under which they could sleep and seek protection from the cold, the biting rain and such vagaries of nature?

A beginning is sought to be made in Hyderabad and Secunderabad to cater to some of their needs. The Forum For Street Children, Hyderabad has been formed.

The United Nation's Declaration of the Rights of the Child did not, certainly, exclude the street child, merely because he was not referred to. The street children have as much right as any other child. Each one of them must have had a father-otherwise, the children might never have been born, Unfortunately, they do not have a Godfather now, some one to champion their right to live with dignity. Understand the situation they are in, understand that they are starved of affection and extend your hand of friendship. Let us make them feel they are also wanted. Let us help them to contribute meaningfully to the society. The United Nations has declared that a child has a right, among other things, to enjoy the rights; regardless of race, colour, sex, religion, national or Social Origin.

— Courtesy: The WAIF

Experiment in Bombay's Dharavi Slum

Shashi Sunny

Using children as volunteer health educators is one of the methods being employed in an extensive programme taking place in Dharavi, an area of Bombay that is Asia's largest slum.

According to the World Health Organisation, 400,000 people live in one square mile, and 50,000 of them are the target of a primary health care project directed by Professor Gopa Kothari of the Lokmanya Tilak Municipal Medical College and General Hospital in Bombay.

The aim is to improve the health and nutritional status of all the people, particularly children under five and women aged from 15 to 45.

The project began in 1981, with an extensive survey of behaviour and beliefs. The results were used to develop health education activities and a community based health care programme with three main components — medical, welfare and social activities.

Three doctors, three medical social workers, a nurse, and 14 community health workers from the staff, with the active participation of local residents.

Training programmes were designed for health workers, traditional birth attendants, child volunteers, and other groups. Immunization, oral rehydration therapy, good nutrition, and personal and community hygiene were major elements in the training, with the young volunteers, aged from eight to 14, carrying the messages home to mothers and grandmothers, as well as to other children.

Opening a dialogue with community leaders helped to bring informal health committees into being, and adult literacy schemes were launched, as well as ideas on how to generate income by selling vegetables or making articles for sale.

Competitions were also held for different groups.

Education aids such as posters, flannelgraphs and slide shows were prepared locally, and used in group meetings and at exhibitions.

Experience has shown that the most successful health education activities have been the training programmes, demonstrations of oral rehydration therapy, the production of flannelgraphs, and the establishment of a printing unit to produce posters.

Cookery demonstrations and the provision of small feeding centres have also been successful.

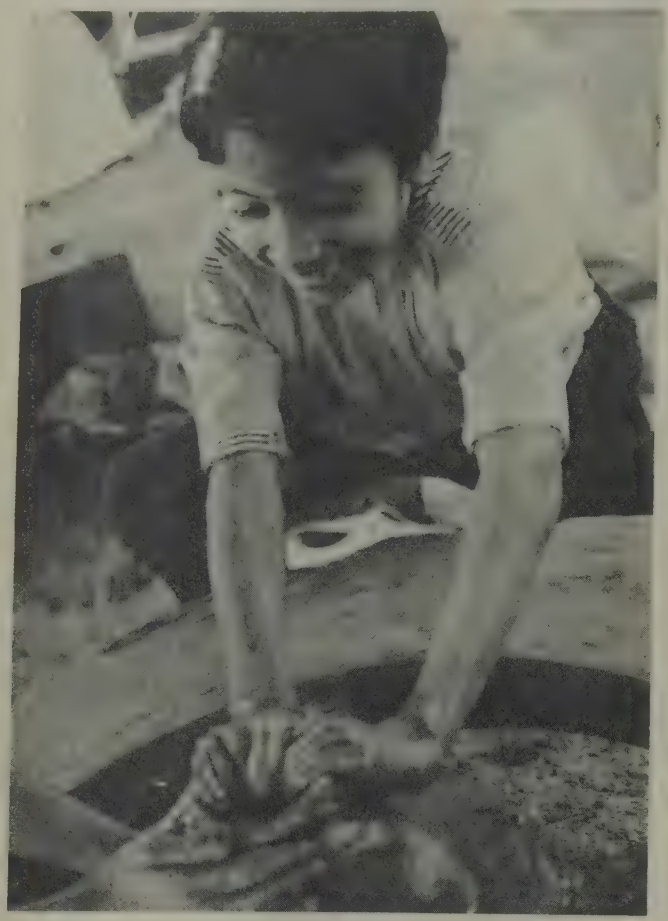
Evaluation shows that, since the programme began, breast-feeding has increased from 60 per cent to 90 per cent and immunization rates have increased to 100 per cent, except for measles which has risen to 60 per cent from a low base.

A 68 per cent improvement in personal hygiene has been noted.

Courtesy: The Congress Weekly

To Dream, Perchance to Do

Seven ways to help a youngster do his best



Parents can help their children realize that the goals they have set for themselves can be reached with effort, perseverance, and just a little patience. The following suggestions may be a useful starting point for encouraging your child to do his best.

Support his effort

Listen to your child's dreams, goals, and ideas, and help him to work out the steps of those that seem attainable. Support his efforts by helping to gather materials and working to break a project into doable parts.

Encourage follow-through

Praise children for completing tasks. It is natural to give up when enthusiasm wanes, but we can help children to strengthen their ability to follow through by gently encouraging them to complete projects or carry on even when the initial excitement is gone. Share your struggles to complete things you have started and the satisfaction you feel in achieving a goal.

Offer reinforcement or rewards

Give your child incentives for his efforts,not just accomplishments. These can be stars on a chart that lead to a bigger reward or even money. But the reward should come for completing the task, not the grade it gets. The more resistant or the younger a child is, the quicker the reward should be given for trying.

Recognize his success level

When a child is frustrated in schoolwork, sports, or any project, help him to go back to a level where he feels successful. When a child returns to a level where something feels easy, he will regain enthusiasm. This is a technique that well-trained tutors and learning specialists use.

Involve friends and teachers

Tell your child's teacher, coach, or baby-sitter that it's more important to you for your child to feel successful than to come out on top. Many professionals feel pressured by parental expectations. Making your values clear can help them more effectively help your child.

Point out efforts in others

Make your child aware of how others put effort into their daily activities. Children can be made aware of how other people work hard at things so they know they are not alone in trying, getting discouraged, meeting challenges, and succeeding.

Praise him for trying

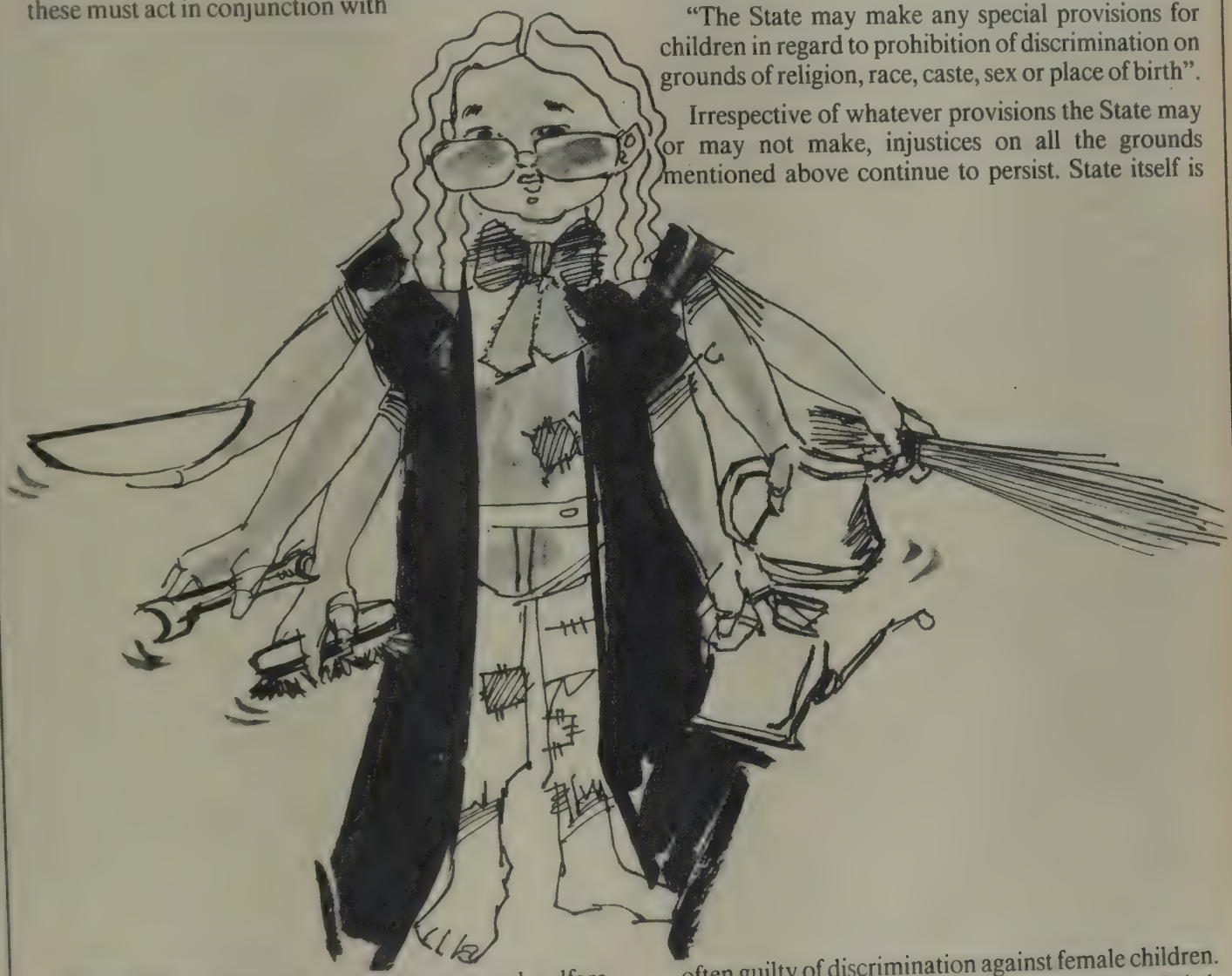
Point out how much you appreciate your child's doing something that is particularly hard for him. When a child tries to control a habitual behavior or does something that he's afraid of or doesn't like to do, he needs particular encouragement. — **Parents**

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

Laws governing children

K Shanmuga Velayutham

Children constitute more than 40 per cent of our total population and they are the most vulnerable section of a society. There are over 250 central and state statues concerning children. Laws are essential to protect and help children, but to achieve this aim, these must act in conjunction with other programmes and measures for care and welfare of children. Children are supposed to enjoy special constitutional and legal rights but they are unaware of their rights and in many cases have no means of enforcing these rights or moving a court of law. They tend to be exploited in a society where a substantial majority of people are poor and unable to maintain themselves.



Discrimination:

Article 15 (3) of the constitution, dealing with Fundamental Rights states:

"The State may make any special provisions for children in regard to prohibition of discrimination on grounds of religion, race, caste, sex or place of birth".

Irrespective of whatever provisions the State may or may not make, injustices on all the grounds mentioned above continue to persist. State itself is often guilty of discrimination against female children. Prejudice on the basis of caste, religion, place of birth and language are rampant in our society. Female infanticide continues to be practised in rural India. Children belonging to all economic strata imbibe these prejudices. Societies perpetuate the existing

injustices, making a mockery of the constitutional provisions.

Child Labour:

Article 24 of the Fundamental Rights prohibits the employment of children below the age of 14 years in factories, mines or any hazardous employment. There are a number of laws which regulate and safeguard child labour in different industries and occupations. Thus for example, there is Employment of Children Act, 1938 which deals with children employed in the type of work mentioned there. Various other Acts also affect child labour e.g. The Factories Act, The Mines Act, The Plantations Labour Act, The Bidi and Cigar Workers (conditions of Employment) Act, The Motor Transport Worker's Act, etc. While there are numerous laws that restrict or regulate the employment of children, the criteria for such restriction or regulation are not always uniform.

Nevertheless, child labour is a fact of life in India, and is accepted unquestioningly by everybody including the child. A conspicuous omission in Indian legislation is the aspect of child labour in the agricultural sector, where 80 per cent of all child workers are employed. Even, The Factories Act which set down standards, does not apply to small industries and cottage industries.

Recent thinking in India, seems to be that child labour in itself is not an evil. It is only when it is accompanied by overtones of exploitation that it becomes abhorrent.

Child Welfare Services:

The children's Act and the Juvenile Justice Act, have adequate provisions for child welfare. The National Policy Resolution for children, 1974 lays special stress on the responsibility of the nation for physical, mental, moral and social development of children. Still in some states there are no child welfare institutions. Even in those states where laws and welfare institutions exist, it is impossible, due to several restraints, to follow the letter of the law. This is one area that amply illustrates the truth of the maxim "The law by itself cannot ensure justice".

Child Marriage:

The Child Marriage Restraint Act of 1978 is one other example of an unenforceable legislation. This Act updates the 50 year old Sharda Act. Under the new law, "no boy under 21 years and no girl under 18 years be allowed to marry". One wonders how many, especially in rural areas have even heard of this piece of legislation, or, having heard, would pay heed. The law is broken all the time, often with parents and the religious priests who perform the ceremony actively conniving to break the law. Absence of birth registration in many cases makes computing the ages of the bride and bridegroom next to impossible. Young children, physically and mentally immature, enter the state of matrimony totally unprepared for its responsibilities.

Juvenile Delinquency:

Even though government passed the Juvenile Justice Act dealing with juvenile crimes, the setting up of a sufficient number of juvenile courts and correctional institutions are much to be desired. To this day, there is no progressive legislation on child adoption in India. No legal aid is available from the States to children, whether neglected or delinquent against whom proceedings have commenced.

Handicapped children:

There is no exclusive legislation for handicapped children. They should have the right to receive, free of all cost where-ever necessary, medical, surgical and all other kinds of rehabilitation, treatment, the aids, appliances and equipment, the use of which may reduce the adverse effects of his/her disability and restore his/her functional abilities, medical, educational, vocational and economic rehabilitation and welfare assistance and services and an inalienable right to work and to full participation.

Children are also not in a position to enforce these safeguards that any legislation may provide them. Hence while considering legislation for child protection and child welfare it is extremely important to ensure that, (a) children do get adequate legal protection, (b) legal provisions are made for children's welfare i.e., their health and education, and (c) there is a suitable machinery provided by law for the enforcement or implementation of these provisions. In the absence of such a machinery for implementation, legal protection however, well designed, may prove ineffective. Ultimately, it is the State that can ensure justice for children.

Rights of the Child and Ethics

George Lobo S J

Almost half the population in India is made up of children. Children are human beings who have not yet fully developed their basic human potentialities and hence are still very much dependent on others. Still, as human beings, they have the same basic human rights as grown ups. It is up to adults to recognize, defend and foster them.

Human procreation should come out of responsible choice. Every human being, because of his or her intrinsic dignity, has the right to come into a home and society that will provide necessary protective care until maturity. The basic obligation is of parents, then of the local community, and finally of society.

Parents are duty bound to provide the love and care which children deserve and require. They have to be supported by others in fulfilling this role. The parents should not pursue other interests to the detriment of their children. They must have their priorities right while building their home. Their own fulfilment and the welfare of their children demand that they do not spend money or energy on any activity that the children's physical, emotional or mental health suffers.

Children need adequate nutrition for their full development. This should not be neglected while money is spent on addictions to vices such as drinking and gambling. A balanced diet and other basic needs of the family should always come first.

One of the most unfortunate features of Indian society today is the gross discrimination against female children. It starts in the womb itself. The technique of amniocentesis is misused for sex selection. If the test indicates that the fetus is female, it is summarily aborted. Thus the lives of thousands of baby girls are snuffed out even before they see the light of day.

The prejudice against girls leads to infanticide in certain parts of the country. The preoccupation with dowry motivates to some extent this horrible crime against humanity.

Baby girls are often neglected in the matter of food and care. When they grow up, they are looked upon as a burden. Later, they are confined to the home or made to work in the most deplorable conditions.

Such discrimination is not only a violation of the right of female children, but a blot on society.

In a poor country like India, it is but natural that children are involved in some productive activity from an early age. Doing some household work or taking part in family enterprises in a limited way may be understandable. The latter may also be a good way of gradually being initiated in some traditional skill. But it should never be at the expense of basic education and normal growth of the child.

Parents should, under no circumstances, look upon their children as a source of cheap or unpaid labour to be used merely for gain. Some parents will come to regret the burden they have placed on their little ones when they get sick and have to be treated with much expense and trouble.

However, what needs special attention is the over 40 million child labourers. They toil in dangerous sectors like match and cracker industries, glass and bangle factories, diamond cutting, carpet making, power loom and zari industries.This kind of work in hazardous conditions takes a heavy toll in terms of the health and even life of the children. Millions of them suffer in a short time from debilitating disease and become invalids prematurely.

The state has a duty to enact laws to curb the evil. But any legislation in this regard would be difficult to implement without a general level of conscienceness. There would be the need for vast numbers of social workers and such others to see that the laws are implemented.

To begin with, the state should try to mitigate the evil of child labour by improving working conditions of the child labour force.

The medical profession too has an important role in this sphere. Medical personnel must draw attention to the causes of the severe ailments they treat. This would be an important contribution to preventive health care. Their voice is likely to be heard more readily by the government and the public.

Role of Consumers:

Buyers of goods of hand woven carpets and textiles with zari work, want them at cheap rates and given the huge profit margin of enterpreneurs and intermediaries, there is little left for the workers.

So each time when the consumer buys an item of this sort, he or she must be aware of what it costs in terms of human misery to produce it. The product often is the result of insufferable pain and permanent handicap for the makers.

The craze for crackers which are produced at great risk to child workers goes on unabated. Even households that are starving otherwise cannot resist the pull of crackers. There is need for people to reflect on the hazards connected with only a moment of joy and excitement.

Child Abuse:

A low esteem for the dignity of the child leads to all manner of abuses. Parents, in their impatience and anger, batter their offspring cruelly. Frustrations may also be resolved by this kind of cruelty.

Some people even resort to sexual abuse of children. This may take a heterosexual or homosexual form. A large number of girls are violated by neighbouring adolescent boys or even by relatives. This may result in a lasting trauma for the child. Such abuse can be curbed only by greater vigilance and inculcating in all a profound respect for the female child.

It is well known that young girls are kidnapped during fairs and other such crowded gatherings in order to later use them as prostitutes. Some adolescent girls are offered to a deity but used for such purposes in some places. Others are enticed by lure of a career in the city. There are cases even of parents selling their young daughters for prostitution because of extreme want.

As this evil has wide spread social ramifications, it is very difficult to tackle. But society must be alerted to the misery of hundreds of thousands of girls who are sacrificed to the lust of men and those involved in the flesh trade.

Child marriage itself is another form of child abuse. The provisions of the Child Marriage Restraint Act forbidding the solemnisation of marriages below the age of 21/18 must be strictly followed. The medical dangers from premature pregnancy should be made known to all.

Another horrible abuse is that of mutilating children in order to profit from their earnings through beggary. It is indeed a crime against humanity to gain some financial advantage by this form of gross exploitation of innocent children.

The gross discrimination against female children in the matter of medical treatment and care should also be done away with.

Psychoactive drugs should not be given to control the hyperactive behaviour of a child merely for the convenience of the family or guardians.

The parents are duty bound to care for the child with love.

Improving Preschoolers' Verbal Skills

Parents can measurably increase their two-and-three-year-old children's verbal skills simply by changing the way they read picture books aloud.

Human Life

(A Pediatrician's Advice for Family Life)

Robert L. Jackson M.D.

The family, society's most vital and basic human institution, is being affected adversely by profound and rapid changes resulting from the gradual adoption of unnatural ways of life.

After over fifty years of pediatric clinical experience and fifty years of marriage, it has been the author's observation that to establish enduring families in our more complex society, it is equally important both for boys and girls to complete their formal basic education and be self-sufficient before marriage. After marriage, both will have grave family responsibilities requiring sacrifices for each other. The boy should be a man in a position to support a family and with basic knowledge of reproductive physiology. The girl should be a mature woman with knowledge of her fertility and with sufficient education to support herself and her children should the need arise.

As a pediatrician, my concern has been to help parents accept, love and enjoy their children by learning and understanding good health practices. It also has been my observation that more than anything else, children need unselfish parents. Unselfish meaning a full time mother and a responsible and loving father, during infancy and the critical preschool years when physical growth as well as emotional and intellectual development are proceeding so rapidly.

The first child in any family has inexperienced parents but if the child is wanted and accepted, the parents learn a great deal in a very short period of time. The second child arriving in about two years will not only extend the education of the parents but automatically provide the discipline especially needed by a first child. Three or more children spaced at about two year intervals are desirable for most healthy couples living in a stable environment. The cooperative help of mothers and fathers in families provides the ideal role models for normal sex identification during infancy and the preschool years.

My advice for enriching and stabilizing family life for our youth and for future generations is summarized as follows:

It is very desirable for girls and boys to complete their formal basic education before marriage.

The boy should be a man in position to support a family and with basic knowledge of reproductive physiology.

The girl should be a mature woman with knowledge of her fertility and with education sufficient to support herself with children should the need arise.

Soon after marriage, it is preferable for most couples to prove their fertility.

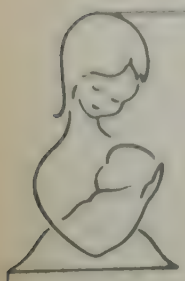
For the first nine months of intrauterine life an infant needs a mature well nourished mother.

Labour and birth need to become again a natural and acceptable life experience for both parents.

It is preferable to space children about two years apart by biological breastfeeding and fertility awareness.

Each couple ultimately has to make the grave decision as to how many children they can care for and educate. (I recommend three or more children for healthy couples living in a stable environment. Many mothers have told me they cannot understand why their third child is so "good" and such a joy. The simple answer is that this child and future children have loving and experienced parents and siblings).

(For clarity in the following statement, I will refer to the baby as she). Love your baby by feeding her when she is hungry, changing her when she is soiled, and protecting her from all dangers. Enjoy your baby, play with her, talk to her and don't be reluctant to cuddle and handle her. You don't spoil a baby with tender loving care. Learn to know your baby-what she likes and dislikes. Each new baby is unique from any other baby who was ever born or ever will be born.



Breastfeed your baby. Biological breastfeeding consists of (a) feeding only human milk for about six months; (b) suckling on demand day and night after about six to eight weeks(most full term breastfed infants sleep from the late evening feeding until an early morning feeding, i.e., for about five to six hours); (c) using no pacifiers; (d) gradual introduction of only small amounts of selected foods at about six months; (e) continuation of nursing as the primary source of food for about one year.

The advantage of breast feeding are:

1 Breast feeding reinforces mothers' and babies' love for each other on regular basis.

2 Prolactin, a hormone, is secreted promptly in response to nipple stimulation which calms the mother and also automatically suppresses ovulation.

3 Milk from a healthy mother meets all the nutritional needs of a full term newborn infant for about the first six months of life.

4 The composition of human milk changes daily (especially during the early critical first months after birth) to meet the rapidly changing needs of a young infant. It's like having a new formula made special for your baby every day.

5 Babies have very strong sucking desires, so nursing will satisfy not only her appetite but also her desire to suckle, and make her unlikely to be fussy; and nursing also makes the mother more calm and motherly.

6 Human milk will protect your baby from many infections. The first milk (colostrum) and early transitional milk contains many anti-infective substances which decrease not only the incidence but also the severity of infections.

7 Breast-fed babies have fewer allergies. Human milk protects against sensitization to cow's milk, and other nutrients needed by young infants who are bottle fed.

8 Breast-fed babies smell better-as: (a) they are less likely to spit up and human milk doesn't smell rancid as does cow's milk; (b) the stools of breast-fed infants are not putrid as are stools of bottle-fed babies; and (c) diapers will not smell like ammonia and cause diaper rash.

9 Breast-fed babies are much less likely to spit-up, vomit or have diarrhoea and never are constipated.

10 Babies breast-fed on demand usually are content and much less likely to have colic in the early months and less likely to have emotional problems related to eating and sleeping as they grow older.

11 Human milk is always ready and needs no refrigeration or preparation.

12 Nursing requires only that the mother eat a little more high quality food so it is much less expensive than buying expensive formulas, bottles, nipples, etc.

13 Breast-fed infants have many less dental problems in later life; i.e. less dental caries and malocclusions often requiring very expensive and uncomfortable dental care.

14 "Biological" breast feeding suppresses ovulation and doctors now understand why this happens. Only "token" or partial breast feeding has been customary in many cultures and we all are aware that this kind of nursing has very limited and unreliable contraceptive effects. If the mother's milk supplies the only food for her baby during the first five to six months and she continues to nurse at frequent intervals as the baby begins to be given only small feedings of selected high quality foods during the second half of the first year, she is very unlikely to begin menstruating and ovulating again until about 9 to 18 months depending on how often the baby suckles and how much milk the mother continues to produce.

As a finale, I synthesize some of my prescriptions for teaching our youth how to understand why it is preferable and more rewarding to live in harmony with nature. Adolescents especially need role models and factual information to help them understand why and how to cope with their normal sexual desires, how to live a fulfilled life in spite of unfulfilled desires, and that the abuse of sex can lead to very serious and never ending problems. After marriage, couples should prove their fertility, and

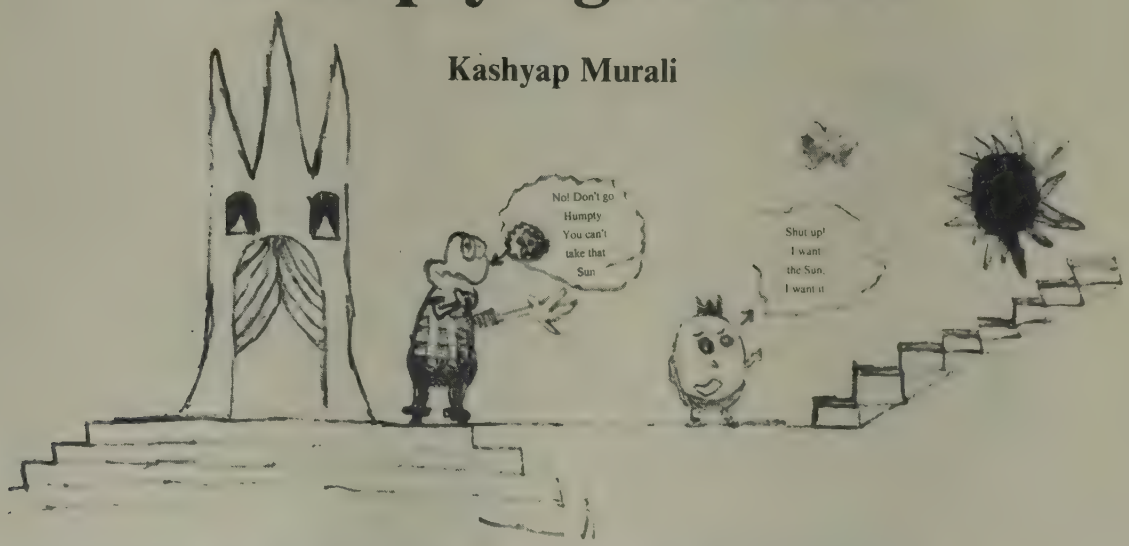
then space their children about two years between births by biological breastfeeding and knowledge of fertility awareness. Both parents need to understand that during pregnancy and for about a year when the baby is truly breastfed the wife does not ovulate, so conceptions are controlled naturally. Consequently, during the early years of married life, sexual abstinence is limited primarily to times of illness or separation, and for about six weeks between births. The period of involutionary changes after birth in a healthy woman is shortened considerably by natural birth and by biological breastfeeding. When the couple decides to widen the spacing or to stop having more children, natural conception regulation will still permit them to have new honeymoons every month, and after only a few years they will begin to recognize the symptoms and signs of approaching menopause. Before long the wife will become naturally sterile with intact female organs. Sexual abstinence is much less difficult for a mature unselfish couple with a secure family.

Natural Family Planning in all of its aspects offers the best hope of overcoming the sense of foreboding for the future resulting from the moral vacuum that is enveloping our civilization. A new peaceful era is attainable if the scientific discoveries and technological advances now available can be applied for constructive rather than for destructive purposes and we modify the distribution of world resources on the basis of social justice in order to permit the emergence of an ecological society. In recent years, there is an increasing realization that we need to revise and extend maternal and child health programmes to attain and maintain higher degrees of health. Observations and experience should teach physicians and other health workers that interfering with natural processes in healthy persons, invariably results sooner or later in varying degrees of detectable pathological changes. Our long-term objective should be to have stable familes with healthy children. There will never be too many well-cared-for children in the world, for in the children resides the real hope for a more peaceful future.

Stop slaying your child with peer pressure. Allow them to nurture their in born talents

Humpty's greediness

Kashyap Murali



As the story of Humpty, who was greedy for gold that he would not stop aiming at the Sun, tried reaching it and melted in the process, children do realise that they can't aim at the moon, but children of well-to-do and urban parents do feel most of the time that they can ask for anything & their loving over-indulgent parents will oblige — to suppress their guilt at the expense of the child.

A self appraisal

By C W C

That the plight of the working child demands a fresh evaluation cannot be over-emphasized. The hardships that the working child is being subjected to the world over, compels one to re-examine these precincts and the harsh realities that govern his/her life. It is this kind of a reckoning that has necessitated the coming together of a group of people from diverse disciplines such as trade unionists, educationalists, academicians, film makers and lawyers to consider afresh the problems of the working child and the remedial measures. The informal functioning of this group which started in 1980 was formally registered in 1985 as THE CONCERNED FOR WORKING CHILDREN.

"I am somebody : I may be poor — but
I am somebody : I may be in prison — but
I am somebody : I may be uneducated — but
I am somebody"

Jesse Jackson

To say that the problems of child labour has become one of the biggest banes of our society is to state the obvious. Factors like rapid industrialisation, urbanisation and lopsided development have added other dimensions to the problem. How does one deal with this monstrosity? The naive among us will refuse to recognise the existence of child labour. Reason? Child labour has been banned through concerted legislation. Therefore it does not exist. Some who are kind may see the problem but venture into a balming process which is no cure. Our endeavour is not merely to treat the wounds but to get to the very roots and arrest this cancerous spread.

The laws formulated about child labour in India so far did not in any way benefit the child. If anything it only worked to his/her detriment — till a new legislation in the form of an Act came into being in 1986, bringing into sharp focus the numerous

hazards of child labour and providing for some remedial measures at the same time.

Compelling social and economic factors drive children below the age of 15 years to work and there was no way they could be mobilised into a trade union. Frequent appeals to managements or the various government agencies to realise the harsh realities of child labour only resulted in an abrupt cessation of employment opportunities to the working child. In terms of actuality, it only meant unemployment for the child resulting in virtual starvation. In the absence of any real protection under the law, the children who are employed illegally are exploited to the hilt by unscruplous 'Masters'.

Long and arduous working hours and low wages contribute further towards making the life of a working child more miserable. He/she is totally denied the protection the regular worker is entitled to under various enactments. Lack of any protection against the hazardous conditions, leads to the lurking fear of the imminent industrial calamities that could mean death to the working children or maim them for life. These circumstances lead the child to a premature adulthood long before he/she has become an adult. And the hostilities of his work place treat him like a full-fledged adult denying him the pleasure of childhood.

"It is honest to say that all children are born equal, if later they are not equal, it is our fault and we have to find the remedy."

Letter to a teacher (by the school of Barbiana)

The main endeavour of the CWC is to ensure a better future for the working child in the face of various hostilities.

The CWC aims at reaching out to different groups of working children and making them aware of their rights in the changed situation.

Further, the organisation works at different levels from advocacy, research and documentation, field programmes with different groups of children, to interacting with similar international organisations. Sceptics are bound to murmur whether we have the requisite force to influence policy at the government level. Yes indeed, we are aware of our limitations. Our lone voice is not robust enough to be heard by the government. In the absence of the kind of awareness one expects on the part of the government on child labour, influencing policy does seem a far cry. We do not of course want child labour legalised through legislation as one is wont to think. Our ultimate aim is to eradicate child labour in all its ramifications. With this objective being uppermost in our mind we have been projecting the stark realities of child labour to the government through various social organisations and the private sector in the hope of achieving the desired results. Our work for the last six years in the field, though hard, has been a very rewarding experience. Especially, working directly with the child has enriched us all.

What does CWC want to do ?

The problem of child labour cannot be seen in isolation removed from its social, economic, political and cultural contexts in which it is deeply embedded. For the same reason, there cannot be any immediate or short term solutions.

"Feel the dignity of the child. Do not feel superior to him, for you are not."

GOETHE

Compartmentalisation of the problems of the child relating to health, labour, education and vocational training in various programmes and projects do not have any remedies either. Such an approach will serve only as a dressing over the wound but would never attempt to cure the disease.

Any programme worth the name dealing with the problems of the working children should necessarily have to be comprehensive and should attempt to deal with the root causes of the problem. Remedial measures so thought of must have the elasticity to be implemented on a large scale. Our aim is to develop successful feasible and self sufficient models that are easily replaceable by governmental or other non-governmental bodies. Our programmes for these children aim at providing the child skills that include literacy, vocational education and subjects of general interest. Environment and appropriate alternative technology form the main part of the curriculum. We

encourage the children to form and be a part of the common independent organization to enable them to discuss and voice their concerns more effectively. We encourage the child to question and to arrive at logical solutions to problems. In addition we enable the child to recognise the usefulness of his/her own work and these efforts go a long way in creating a sense of awareness, identity and dignity in the child.

With such an approach towards an all-round development of the child, we hope that these children will grow up into strong adults, able to make useful contributions economically, socially, culturally and politically. In these efforts, the innumerable causes of child labour, which mainly stem from tradition and the political system which impede development, are not lost sight of.

Detailed discussions on such factors are held in the hope of proposing alternate plans to the departments concerned with the ultimate aim of being able to influence policy. This might give one an impression that we are in a fool's paradise. We reckon this is a long and difficult task where sincerity of approach may easily make way for cynicism. Unless we are able to visualise these problems in all its complexity and generate adequate attention and support, the problems continue to be latent and continue to grow and fester and reach even larger and more horrific proportions.

"The child shall be protected against all forms of neglect, cruelty and exploitation."

The Declaration of the Rights of the Child — UN

How do we care for them ?

The CWC runs one residential and 16 day centres all over Bangalore. We also work in close liaison with other organizations with similar interests, in identifying the needs of working children and meeting their needs through long term education and training programmes. The centres are formed based on the nature of the child's work and the concentration of child workers in certain areas.

The centres are a method of organising working children and through our field staff, foster in them a feeling of trust, hope and self-help by being in their midst and interacting with them. The non-formal education and the vocational training centres create an awareness of the importance of basic education and training.

"Children have neither past nor future and what scarcely ever happens to us, they enjoy the present."

John De La Buyere

They too need to laugh and learn

The assumption that the child in a state of utter deprivity has only economic concerns, is not merely erroneous but totally misleading. Unless sincere efforts are made to discover the latent talents in working children one does not realise the full potentialities of such children. It would be an unpardonable sin to condemn them to their work places with only economic considerations being uppermost in our minds. Hence providing facilities for recreating expression, art and culture is a very important task for a field worker. Child workers gather together to play games, paint, learn puppetry or just sit around and talk as other children love to do. They stage street plays as a means of expression of their inner feelings and sentiments.

"The most deadly of all sins is the mutilation of a child's spirit."

Erik Erikson

Learning through a combination of visual aids, games, songs, story telling and picture charts has increased their learning capacity. Children who have been exposed to schooling late have been able to read and write in as short a duration as three months. Educational tours and picnics to places like the Museum, Bank, post office, children's park etc are organised for the children. They gain a first hand knowledge of the functioning of these institutions which has resulted in children learning to use them meaningfully to their advantage, instead of shunning them as meant only for the privileged.

A trip to the zoo or to a park initiates them to a basic class on botany or zoology. For most children this would be their first exposure to the environment. Such exposures are eventually aimed at creating a new awareness of the various state institutions and the mutual obligations between the children on the one hand and these institutions on the other.

"Through magic the child created a world in his own image."

Octario Paz

How do we train them?

Most children aspire for jobs that give them social acceptability which also pays them well. There is a deep urge in them to put all their talents to full use. In our centres we aid them in identifying the aptitudes of each child and train them accordingly in screen printing, automobile repairs, plumbing and carpentry. The main aim of such vocational training programmes is to create better job opportunities for the children in a highly competitive world which will ultimately render them economically independent.

"Education is helping the child realise his potentialities."

Erich Froman

Some working children have expressed a keen desire to learn to read and write while some others only want to learn a trade. Imparting basic education is not a difficult task as our centres can tailor the timings, syllabus and methodology to suit the convenience of the child. It is pertinent to mention that we also stimulate an interest in literacy in our vocational training centres.

"What we want is to see the child in pursuit of knowledge and not knowledge in pursuit of the child."

George Bernard Shaw

The dedication with which our volunteers approach the many problems that beset child labour is very crucial to our success. Our volunteers play a very important role by interacting with and counselling the parents and employers of these child workers. Many children look upon this task with a certain amount of very understandable scepticism. The child is not convinced about the utility of our programme.

Their harrowing experience of exploitation have made them lose all faith in social norms and institutions. As many of them earn enough to maintain themselves and even pay a little to their family, they shun intervention in their lives from all agencies. Our main concern is to convince them that there is a need to find answers to some crucial questions like job mobility, career development and planning, enhancing the earning capacity of the child and finally share such problems with other children.

The most unique part of our programme is the recreation available for the child. To play, to have fun, to feel secure — in short to have the freedom to be oneself is the biggest incentive for the child. In order to escape from their mundane lives, many of the working children spend a large amount of their earnings on films. Such wasteful expenditure is prevented by providing recreational facilities.

"To be able to catch up into the world of thought — that is being educated."

Edith Hamilton

Realising the importance of involving the parents in the development of the child, our field workers spend a lot of time meaningfully with the children, and their parents to enable the whole family to participate in the development of the child. Without the active participation and cooperation of the parents, no programme relating to the development of the child can at all be meaningful.

Caring for their health

In our Health Clinic not merely are the children treated but regular medical check ups are also done. This clinic also serves as a centre where education in the areas of health, hygiene and nutrition is imparted. This health centre also documents details regarding occupational diseases and Health Hazards suffered by working children. This information is used for remedial measures at various levels.

Going further, not only do we treat the child, but we also create an awareness of health in the child. This health education is ultimately aimed at making the child realise the functioning of the human body so that he/she can take charge of his/her own health, understand what causes diseases and how best he/she could counter them.

After the child has attained a satisfactory level of basic education and vocational training, we assess the child's ability to use and deal with public institutions like banks, post offices, police stations, hospitals etc. This will not stop at merely social and economic activities. We realise that the child will soon grow up to be an adult. These activities are geared at infusing self confidence in the child and are looked up as a process of preparing the child to take on the outside world. On being sure that the child's self confidence has grown and that he can draw from his own

resourcefulness, we try to help the child improve his financial situation through job placements or the formation of cooperatives along with their parents or other dependable adults.

"We must open the doors of opportunity. But we must also equip our people to walk through those doors."

Lyndon B. Johnson

Research and Documentation

Till very recently, the problem of child labour in India did not get the attention it really merited. Child Labour has not been included as a subject for national census by the government of India. Our work with child labour over the past six years has proved that there is a dismal lack of both information and statistics, in the absence of which the total enormity of the problem in all its grotesque proportions does not emerge for a full consideration. Though some information is available, it is sketchy and scattered, inadequate and inaccessible. Most of such information is based on sample surveys done randomly and is arrived at on guess estimates. The national statistics for child labour based on 1981 census is 17.36 millions.

Commissioned by the government of India, the Operation Research Group, Baroda, undertook a national sample survey on child labour. This survey puts the figure at 44 millions. During the same period, the CWC in india declared a figure of 111 millions which has been corroborated by the BALA Data Bank, Philipines. This dearth of information is a direct result of the lack of concern for the working child and has seriously hampered the work of the individuals, groups and government bodies attempting to find solutions through service programmes, research, policies and legislations.

If any meaningful work is to be done seriously in this area, the information, the shared experience of individuals or groups working for these children and schemes and laws need to be studied in depth and analysed so that the resulting data may be put to practical use in the formulation of policies and implementation of programmes.

Some work has already been done by the CWC through case studies of child workers. The information collected by various sectors, both governmental and non governmental working on the problem of child labour, is not adequate.

In an attempt to do away with such inaccuracies and inadequacies, the CWC has started a Centre for Applied Research and Documentation (CARD). Through this Centre, we hope to create an infrastructure to facilitate a better understanding of the situation of the working child in order to improve their working and living conditions and to ensure these children have a brighter future.

We conceive this Centre, will become the hub of network we have with other organisations in India and abroad. We wish to involve as many like minded organisations as possible in the day work of the Centre to ensure their whole hearted participation and also to share any information they may require.

This centre will also help organisations to document their experiences, their success and failure in the hope that others could learn from it.

In addition, this Centre will also work with the various departments of the government to assist them in the formulation of programmes and policies for the working children.

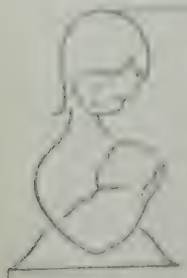
We visualise this as a vital, active participatory Centre that will cater to the needs of not only the CWC but other organisations or individuals with similar aims, objectives and visions.

Training programme for the concerned:

The CWC is actively involved in training all the personnel engaged in our various programmes connected with vocational training and field studies. Any outsiders who wish to work with us or who are already involved in child labour, are welcome to join us for a better understanding of the problems. We continually monitor and evaluate our projects.

Video films are being made on case studies which depict the growth, the development of a child, his needs and problems, factors leading to his neglect, destitution, abandonment and delinquency.

In addition, a detailed documentation of the difficulties of the implementation of various legislations dealing with child labour, with particular reference to the Juvenile Justice Act has already been undertaken. Such material will enable specific target



groups like the police, the judiciary, social workers and other functionaries to appreciate better the problems of child labour. All this is done either by CWC independently or with the assistance of other agencies such as EDUCARE, SHRAMIK VIDYAPEET and individual resource persons.

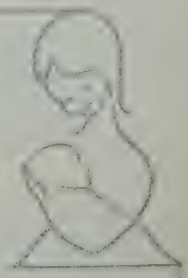
Developing educational material

The present education system has belied the hopes of those who have a result oriented approach to education. This disparagement leaves very little choice for the parents to consciously opt for a job as opposed to formal education. The reason behind opting for a job is fairly simple — at the end of it all, there is no certainity of a job, but a job, however, ill paid, trains the child in a skill which opens several opportunites.

Education for the working child cannot be equated with literacy. The need for literacy will have to be created by satisfying other more urgent needs of the child. Education therefore should be seen as the development of human resources and the child being able to fulfill his/her specific needs and aptitudes. With this understanding we have devised a moral of education which consists of:

(a) Basic concept of Health and Nutrition; (b) Literacy standard equivalent to the 7th standard (in all subjects) Language skills include the regional language and working knowledge of English; (c) Environmental education — linking them to the world outside in a manner by which they would be left with a feeling of contribution and participation. It will also include the understanding of environmental issues and alternative technologies; (d) Awareness of social institutions (and their use), legislations, responsibilities-through this to give them a perspective of how things around them function to enable them to take their place with confidence. (e) Provide help in appropriate skills for vocational training.

The methodology is being culled together by a group of resource personnel. The prime mover of the



programme is the social worker who enjoys a good rapport with the child. The whole process is to be closely documented and it is hoped that at the end of the experiment a manual for training the social worker, a manual of course content and a manual of teaching aids will be possible.

We share our concern with others:

The dissimination of information by way of seminars, workshops, discussions, campaigns, audio-visual aids, a Newsletter and a close rapport with the media is another function of the CWC so as to initiate and maintain a certain level of public awareness regarding problems of child labour in India.

We maintain an expanding network system which is both national and international through correspondence, forums, committees and a news letter. We hope to play an important role by keeping people informed.

Through active participation with other organisations and by sharing information we hope for an increased awareness to achieve better prospects for the working child in India.

Rural reach

On January 1st 1989, the CWC started a rural centre at Basrur, South Kanara district, Karnataka. The main focus of this project is on the working children concentrated in the areas of tile industry, beedi factory, cashewnut industry and agriculture.

The work is seasonal as far as agriculture is concerned. The children are unemployed during the other seasons and take to the streets. In other areas, children are made to work for very long hours and are invariably exploited by the employers. This centre will help educate these children through nonformal education where a desire to learn will be instilled in them. Health, hygiene and nutrition will receive emphasis. Educational tours will also be conducted to motivate and create an interest in the world around them. Vocational training will be imparted to children who have an aptitude for skills which will provide them better job opportunities. The children will also be provided with facilities for recreation and culture. An interesting and unique feature at Basrur will be a mobile library which is essentially a cart drawn by a cycle, which will educate and create an awareness among the masses. The administrative office has started functioning already. Mr Damodar Archarya, who is one of the activists of the CWC is in charge of the project. We are now in the process of recruiting the staff for this project.

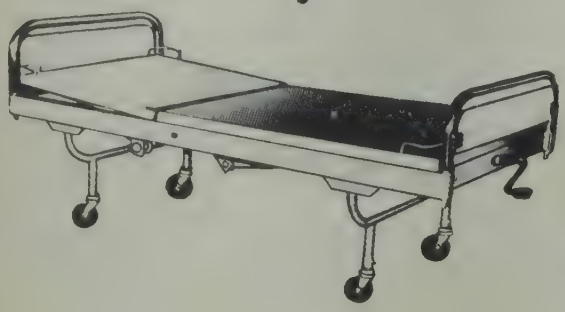
The CWC is constantly interacting with the government of india as it is felt that it is the only body which is capable of tackling problems of child labour in all its enormity. We liase with the government very closely in the formulation of legislation, policies and programmes. Areas like health, education, child welfare and labour receive very special attention from us. This close interaction is made possible by individuals within CWC being members of various governmental bodies.

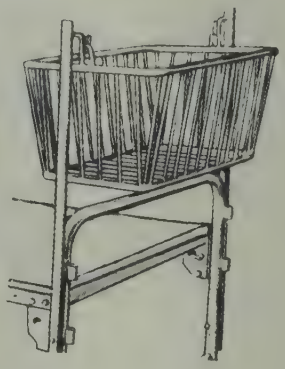
One child wanted very much to eat an ice-cream, but her mother forbade her to eat saying that ice-creams are cold and that she would catch a cold. So the girl took the ice-cream and warmed it over the gas-stove and found to her chargin that the ice-cream had melted all over the gas-stove.

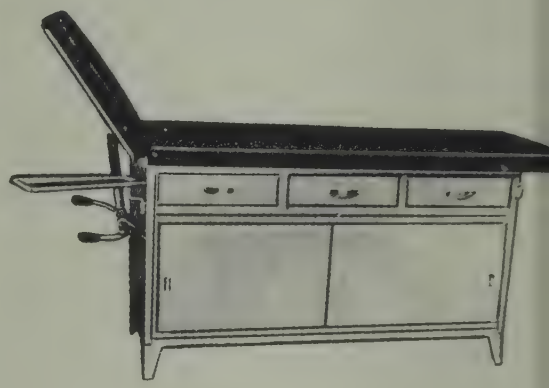
Sangeet Kaur, four years
Tinty tots, Nursery School

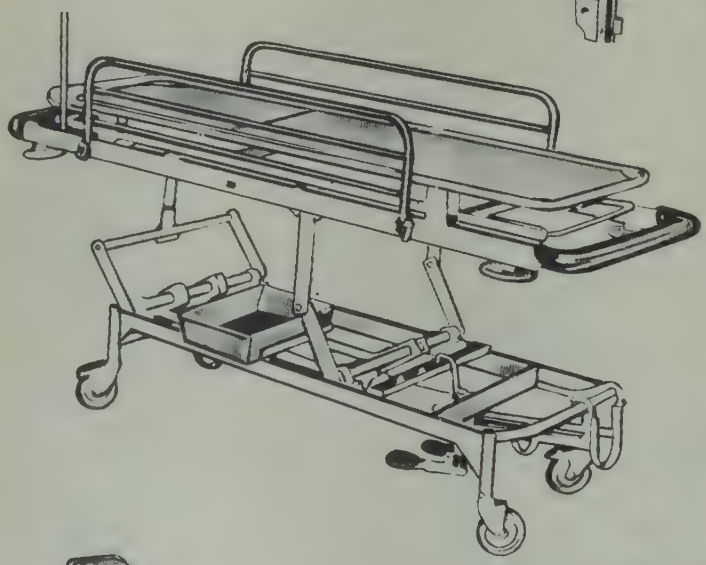
PATIENT CARE EQUIPMENT

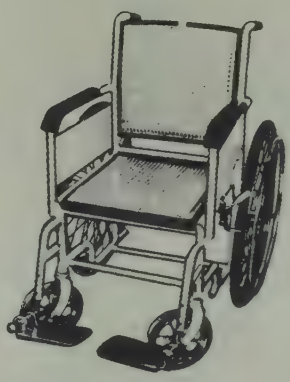
JANAK

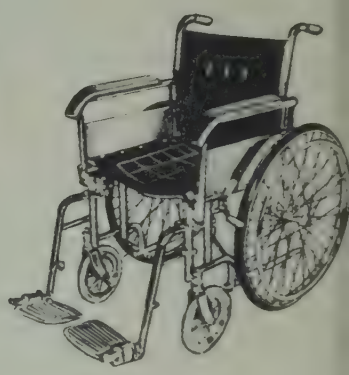


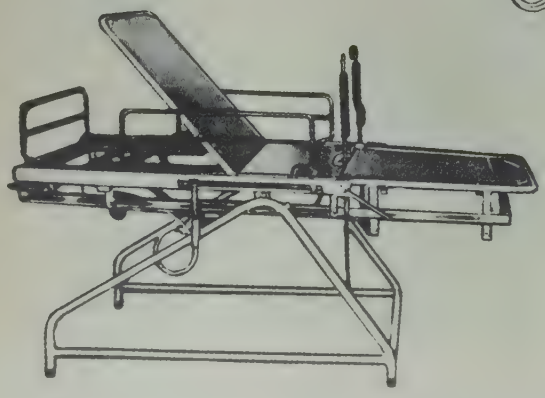


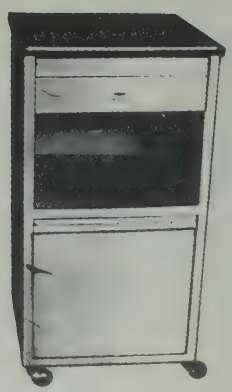












METALBEDS INDIA

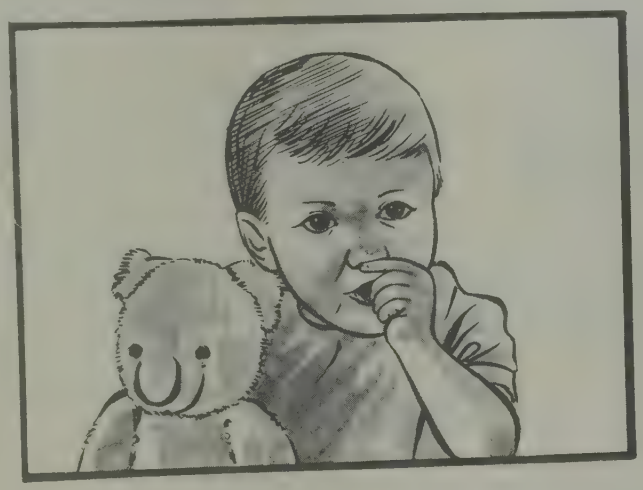
Janak House, Sheikh Misry Road,
Wadala (East) Bombay 400 037 (India)
Tele: 412 0171
Tlx: 11-71584 JKMG IN
Cable: JANAKBED MT

Growing up-pains

Thumb-in-mouth

Why do children suck their thumbs ?

Thumb-sucking begins naturally in about 50 percent of infants in this country as a result of a basic need to suck that begins even before birth. Researchers have reported that some fetuses suck their thumbs in utero! And some infants are born with sucking calluses already on their thumbs. All babies are born with a sucking reflex as well as a need to suck, although the intensity varies from infant to infant.



A diminishing need.
According to pediatrician Benjamin Spock, the baby's strong need to suck naturally and gradually diminishes, beginning at about six months of age (at the earliest). Once babies develop the habit of sucking, however, they continue to do so, not because they need to but because they discover that thumb-sucking provides them comfort when they are tired or feel a bit out of sorts.

By the time these babies become toddlers and begin learning how to be independent, they are delighted to learn that their thumb is always available to comfort them when they want. Most important to the toddler who has a strong need to be independent is that he can suck his thumb by himself, without any help at all from an adult!

What should you do?
First of all, if your toddler sucks her thumb, don't worry. It doesn't mean she's unhappy or that you're doing anything wrong.

Certainly, don't punish your toddler. And don't try to get her to stop sucking her thumb by using restraints or by painting something that tastes awful on her fingers. It won't work. More than likely, you'll simply create greater discomfort and increase her desire to suck her thumb more than before.

One thing you might do is to watch to see when your toddler sucks his thumb. Since thumb-sucking is, for toddlers, a comforting habit, your one-year-old is likely to suck his thumb most often when he is feeling out of sorts. Does it happen just before naptime? Try putting him down for rest a little earlier. Does it happen whenever company comes to visit? Help him adjust to strangers in the house by providing extra cuddling and attention.

Whatever you decide to do, don't worry. Your toddler, if he is like most youngsters, will give up thumb-sucking by himself, regardless of what you do. And he will do it long before his permanent teeth come in.

Q: Why should you buy an ESSEN Computer?

A:

- Essen is the largest OEM supplier.
- Essen is the largest manufacturer of peripherals in India.
- Exports of over Rs. 10 crores.
- The unique ESSEN quality with an investment of Rs. 10 crores.
- Essen have manufactured and installed over 7,500 Personal Computers and 500 mini-computer systems.
- Computers marketed and supported by Hinditron.
- Peripherals marketed and supported by Zenith.

The ESSEN Group

Essen Computers Ltd.
Essen Peripherals Pvt. Ltd.
Essen Telecommunications Pvt. Ltd.
Essen Fabrication & Engineering Co. Pvt. Ltd.

An unmatched presence in the computer industry

ESSEN: GANDHI NAGAR • A/7, GIDC Electronics Complex, Sector 15, Gandhi Nagar 382 015. (Tel: (02712) 21607

BOMBAY • B-52-54, Nand Bhuvan Industrial Estate, Mahakali Caves Road, Andheri (East), Bombay 400 093. Tel: 630-0158, 634-5495, 634-4326

Your Child's Moods

"I wish I could figure Sarika out. On some days she is sitting on top of the world and on others you just can't live with her. She's got me totally confused."

We often hear comments similar to this one by the mother of a six-year-old, from frustrated parents who describe their children as moody-in turn compliant and cranky, friendly and withdrawn, happy and morose, peaceful and fairly agitated.

The frustration is understandable. It is hard to deal with anyone — child or adult — whose demeanor seems inexplicably changeable. In the case of children, the challenge can be especially great. Youngsters don't always have the vocabulary to name and describe the mood they are in, and it is hard, therefore, to figure out why their behavior may be so different today than it was yesterday. As one father said of his unpredictable five-year-old, "sometimes, I'm just not certain who the real Ravi actually is."

What's with you, anyway?

Ravi's father was giving voice to one of the dominant issues addressed by social psychologists, the problem we all have in defining with certainty the personalities of others. The truth is that we humans are hardly as consistent as we might like to think. Beginning early in life, our behaviour day-to-day depends on transient circumstances as heavily as on fixed personality characteristics. In the case of the young, those circumstances can have an especially dramatic impact.

The physical connection

To begin with, the child's moods can be significantly affected by physical factors. Doctors and nonprofessionals alike increasingly recognize the intimate interaction between the body and the mind, but somehow we are less prone to acknowledge it in children than in adults.

In part that is because children are not as quick to isolate and communicate their internal physiological feelings. You won't, for example, hear a five-year-old with acid indigestion say, "I haven't felt right since that hamburger" to explain her irritability. You can be sure, however, that when the child's biological equilibrium is disrupted, the psychological climate can change dramatically.

Close encounters

Equally important in influencing moods are the daily experiences a child encounters. Much as we may love and identify with our children, it is by no means possible for us always to know what it is that feels to them like a triumph and what feels like a disaster. Indeed, as many parents recognize, we adults can be far off the mark in our efforts to identify those happenings that are stressful to our young and those that are not.

An affectionate encounter with an admiring teacher can turn the child's psychological weather from cloudy to sunny; a demeaning comment can work the other way around. And a passing caress between Mom and Dad can make the spirit serene while, according to recent studies, even subtly expressed antagonism between them can generate anxiety. Children's moods are often potent signals of the impact on them of life events, and it is not only unwise but unfair to draw inferences about their basic personalities from isolated samples of their behaviour.

Try to understand

Understanding the internal logic of a child's moods can help us avoid the conclusion, as one mother put it, that "there must be something emotionally wrong with this kid." While constant and wide swings in mood may indeed have some clinical significance and thus warrant attention, that is by no means usually the case.

We cannot protect children from the mood-affecting realities of life on this planet. Nor should we try. But we can be more understanding of the physical and psychological reasons for their shifting emotional states and thus more accepting of our young no matter what their passing moods.

— Parents

Indchem

ATL (INDIA)

THE UNMATCHED RANGE
TOTALLY COMMITTED TO HEALTH CARE

Manufactured Overseas :

- Patient Monitoring
  S & W, DENMARK
- Ultrasound Scanners
  ATL, USA
- Computerised Stress ECG
  QUINTON, USA
- Nuclear Medicine & C T Scanner
  ELSCINT, USA
- X-Ray Imaging Systems
  FISCHER, USA
- Holter Monitoring
  OXFORD, UK
- Neonatal Care
  VICKERS MEDICAL, UK
- EMG, EEG & EP Products
  MEDELEC, UK
- Fetal Monitors
  SONICAID, UK
- Anaesthesia Monitors
  DATEX, FINLAND
- Histopathology Equipments
  SHANDON, UK

Manufactured in India :

DEDICATED ULTRASOUND SCANNERS

BEDSIDE MONITORS

DC DEFIBRILLLATORS

ZOLL NON INVASIVE TEMPORARY PACE MAKER

CENTRAL MONITORING CONSOLE

MEDICART TROLLY

Branches : Ahmedabad, Bangalore, Bombay, Calcutta, Coimbatore, Delhi, Hyderabad, Kathmandu, Lucknow, Madras and Trivandrum

CONTACT :
INDCHEM ELECTRONICS LTD.,
231, T.T.K. ROAD,
ALWARPET,
MADRAS 600 018
TEL.: 450205, 454936, 454849

Play

Dr. Srikala Bharath

"All work and no play makes Jack a dull boy" is a very well known but often forgotten proverb. One of the repercussions of fast urbanisation with its resultant focus on academics/achievement is the loss of play/exercise/hobbies for children. Either parents deny/ignore the need of children to play or become highly involved with the training of their children in a competitive play-sport/hobby like tennis or swimming. In either case the right of the children to select his type, and pace of play, with his choice of mates is denied. Is it necessary for our children to play at least for sometime in a day? What are the facts about play/exercise in the development of a child?

Is it not a common observation by the parents that infants lean forwards to bump against the parents forehead while playing 'knock-knock' understanding on their own the concept of anticipation without being told. Children, especially infants, get highly stimulated while being engaged in play by parents/adults and this forms an impetus for learning by the infant. This playful interaction helps the infant or the toddler to develop bonding with his parents.

Expectations as far as preschoolers are concerned are low and hence their deprivation of play is less when compared to the school going children. But, parents often forget that it is play which makes a child a 'social being', initially with parents, later with peers. It teaches a child the necessary social mores of how to behave in a group. Though this is done by sending the child to a school, play does it in a non-threatening manner. Who has heard of a child refusing to play with his friends though one often hears of children refusing to go to school. With smaller families being in vogue a child's first lesson in sharing with others, tolerance of frustration, probably starts only in play situations; for example, an only child who is used to having all his toys to himself at home, has to wait for his turn with a ball while playing with his friends.

Be it indoor games or outdoor games the rules/regulations associated with them help the child to understand the need for order/discipline on a trial and error basis and later make it a part of himself. Victory in play/games enhances self-esteem; at the same time defeat prepares the child to accept it as a way of life. Healthy competition faced by a child in a group game prepares him to face competition in academics/career later in life. It also inculcates the competitive spirit in him.

The child learns more and also effortlessly while at play than while studying. Concepts involved in games like chess/trade test a child's comprehension, reasoning, thinking. It is a natural way of improving one's concentration (who can complete a Rubik's triangle without adequate concentration?) and also accumulate knowledge (through games like Word-Building). Understanding this, many schools at present teach children through play than structured study.

The physical activity associated with play/exercise is a natural vent for the aggression/energy which is in abundance in growing children.

Children often communicate their problems through play. A perceptive parent/adult can usually observe this, for example, a preschooler aged three years, feeling jealous of his new baby brother may be observed to beat up his doll severely.

Play allows a child to be in his or her imaginative world (fantasy) periodically. The real world is perceived less threatening by the child because of this rich fantasy.

Finally, play is the only means when a child chooses to be himself — i.e. 'child' and not what adults expect of him.

Motherhood

–a matter of careful moments

Satavarex

Significant source for Pre and Postnatal Care and Galactopoiesis

COMPOSITION:

SATAVAREX contains Shatavari (Asperagus Racemosus, willd) 20% in the form of Granules.
SHATAVARI contains the following:

Water soluble substances	52.43%
Fibres	33.65%
Moisture	9.45%
Salt	4.46%
Sugar	7.00%

(In Water soluble content)

The main substance is Asperagine ($NH_2COCH_2(NH_2)COOH$) which belongs to the group of amides and hence has been also called asperamide. It is an amino Succinic acid.

INDICATIONS:

- As a Galactagogue for stimulating lactation.
- In ladies it also helps in development of breast.
- In pregnancy it nourishes the foetus and acts as multipurpose tonic.
- As a nutritive Tonic.

DOSAGE:

Just 1 to 2 tablespoonful twice a day with milk.

PACKING:

In utility jars of 200 gms.
SATAVAREX formulated for the care of motherhood.

ZANDU PHARMACEUTICAL WORKS LTD

Learning problems

Dr. Shekar Seshadri

Parents sometimes feel that their children are not doing well enough in school. They may even receive complaints from the teachers to this effect, or the child's progress report may clearly indicate a learning problem.

Learning problems or its result — scholastic backwardness occur in children due to very many reasons, and a proper recognition of these would go a long way in deciding the appropriate strategy to tackle the problem.

To begin with, it is important to find out if the learning problem is of a recent onset or if it has been present ever since the child started attending school. If the latter is the case, certain important causes need to be considered, assuming that the child does not come from a chronically under stimulated background.

Children who have mental retardation are unable to perform well in school from the beginning of their academic career. Such children are slow in most other activities such as play, socialisation, self-help skills and developmental milestones. These children would benefit from training and stimulation.

There are other children who are not retarded but who yet do poorly from early years of schooling. In this regard, the child would have problems in vision or hearing, learning disability, i.e., a specific problem in reading or mathematics etc. or problems in attention and concentration (hyperkinesis). The approaches in each of these instances depend on proper examination and assessment. If the child has visual or hearing disability, these need to be treated; learning disability and attention disability need remedial education in a structured fashion. There are special schools which pay more attention to the needs of slow learners and children with other kinds of learning problems.

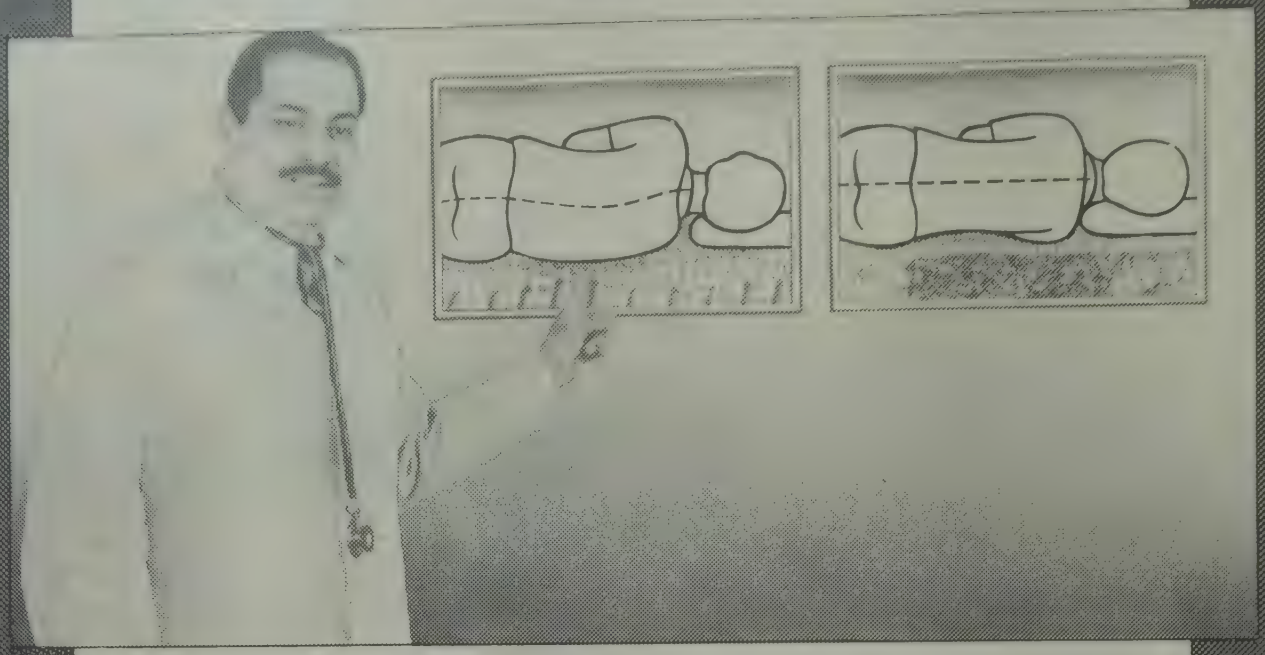
The other situation commonly encountered is that of a child who has been doing well in school but starts manifesting scholastic backwardness suddenly. Here the basic cause may be in the child or in the environment.

Some of the common causes affecting a child are physical illnesses and consequent absence from school, and emotional and behaviour problems related either to school or the family. Children are sometimes temperamentally anxious and may have examination anxiety or problems in adjusting to peers and teachers. Alternately, a child may have problems at home, and pre-occupation with these affects performance in school. Among the environmental factors are a change of school, or medium of instruction, or some recent disturbing event in the family.

In such instances, a detailed evaluation of the family, the child, and school reveal the source of the problem. Family counselling, individual therapy with the child and liaison with the school help resolve the trouble that the child may have.

Recognition and management of learning problems in children is essential for reducing long term effects on the child. An awareness of this on the part of parents and teachers is thus of prime importance in order to help the child develop comfortably.

"The cause of backaches could rest on a bad mattress."



Incredible but true! 15 million adult Indians suffer from that crippling phenomenon – the backache. Because their choice of mattress was either foam or cotton. Clearly the wrong choice for a good rest.

WHY THE WRONG CHOICE?

Because foam sags. Generates heat. And does not give adequate support to the lumbar region of the spinal column. Putting undue stress on the back muscles, hindering blood circulation in that area leading to that familiar, uncomfortable symptom – the backache.

Cotton – even the best – turns hard and lumpy. The body gets inadequate rest leading to body discomfort and, of course, backaches.

WHY KURL-ON?

One look at the inside story will reveal the facts. Only Kurl-on gives the body firm support and just the right amount of comfort. Because only Kurl-on has millions of resilient rubberised coir springs covered with a soft cushion overlay adjusted to every contour and shape of the body. Every part of the mattress 'breathes'. Leaving no room for discomfort or backaches. And all this comes packaged in exquisite quilted tapestry – machine stitched and elegant.

AND FOR HOSPITALS?

There's Restwell. Scientifically designed for use in hospitals. In flat and tri-folding types. With a protective rexine covering to facilitate sterilization.

Yes, its true, for complete comfort, support and elegance. There's no alternative to Kurl-on.

For Comfort. Support. And Elegance.

Kurl-on®

India's largest selling mattress

Karnataka Consumer Products Ltd.
Marketing Division: Industry House.
45, Fair Field Road, Bangalore – 560 001.
Ph: 70769, 72710

On the Other Hand

J.T. Gibson

Sharon, like most babies, was ambidextrous when she was six months old. At one year of age, she began to use her right hand much more than her left. A few months later, however, this preference began to shift. Gradually she began to reach with her left hand even when her mother presented objects to her on her right side. By the time she was eighteen months old, Sharon appeared to have a clear left-handed preference.

Sharon's father, lefthanded himself, was unhappy. He knew that left-handers are a minority in a right-handed world and that everything from doorknobs to ignition switches in automobiles are in the "wrong" place and are hard to use. He remembered how difficult it had been for him in the first grade to learn to write from left to right; no matter how hard he tried, his hand covered his work and smeared it as he went along. He remembered, too, that other children laughed when he had trouble learning simple things, like how to use a pair of scissors.

"Sharon is still so young!" he exclaimed. "Isn't there anything we can do to get her to use her right hand before this left-handedness becomes permanent?".

An inherited trait?

Child specialists agree that the answer to this question is no. Although many youngsters show a preference for one hand for a while and then shift a little later to the other, it isn't uncommon for them to demonstrate a clear choice by eighteen months. The fact that hand preference develops early, however, doesn't mean that it is susceptible to being changed or that changing will not cause problems.

The fact is, handedness, rather than being learned through practice, is an inborn trait that runs in families and is far more dependent on heredity than on experience. The hemisphere of the brain that controls handedness also controls language. According to child psychologists and pediatricians, trying to change handedness is a dangerous practice because it can increase the likelihood that problems, such as stuttering, reading difficulties, or emotional disorders, will occur later.

No cause for concern

Sharon's father shouldn't worry. The fact that Sharon is left-handed doesn't mean that she will be unhappy or that it will be harder for her to learn. Recent research suggests, in fact, that very young left-handed children may actually learn some things more easily that their right-handed counterparts. The problem is simply that there are far fewer left-handed children than right-handed children in the world: Only about 10 percent of boys and a slightly lower percentage of girls are left-handed. So society hasn't gone out of its way to accommodate their needs. Left-handed people simply have a lot more to learn about how to adjust satisfactorily to a right- handed world than do their peers.

Left-hand turn

What, specifically, should you do if you see your toddler begin to show a preference for his left hand?

Allow him time to develop a preference. Watch carefully what happens. Keep offering things to his right hand and see which hand takes them. If after a time he consistently uses his left hand, don't fight it.

Be supportive. Give him more help with crayons or with placement of paper when he begins to draw than you would a right-handed child. Later, when he's ready to use scissors, give him a pair of left-handed scissors.

Remember that supportive behavior needs to come from everyone. Tell baby-sitters, grandparents, and everyone who takes care of your child that you want him to learn comfortably how to use his left hand. Explain to them exactly how they can give your child the support and encouragement — he needs.

Nurture your child with love

"I am So Angry!"

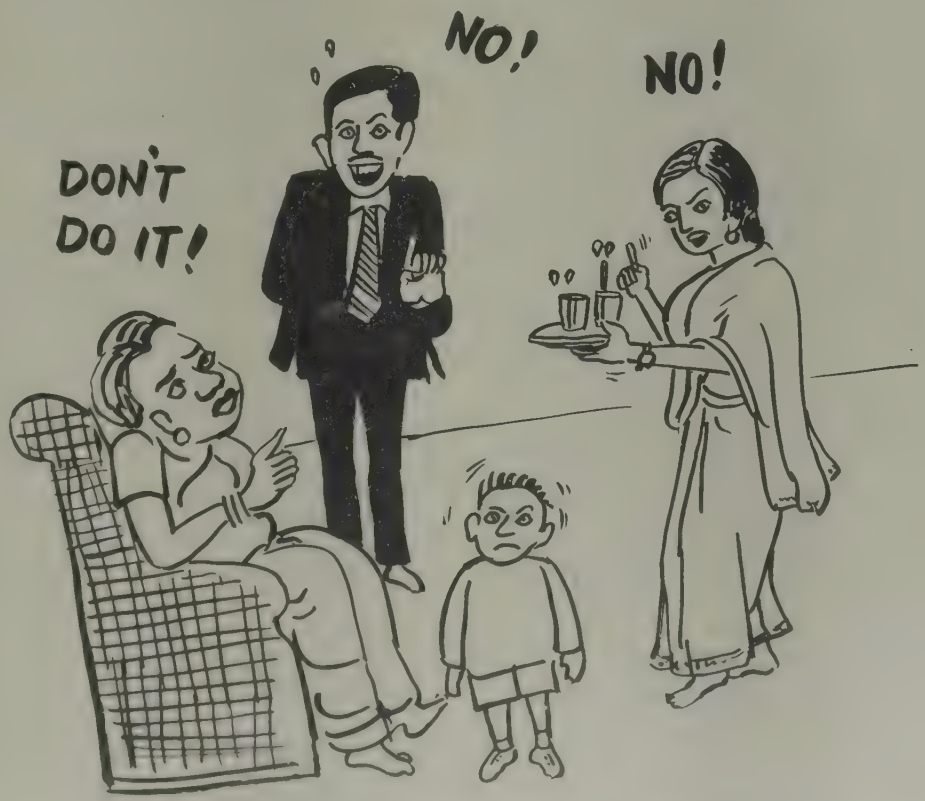
Julius Segal

The preschooler in the market kicks and screams when her father refuses to stop at the toy counter... The nine-year-old, hearing his sister poke fun at his table manners, abandons dinner abruptly and storms into his room, shouting obscenities along the way... The adolescent, told he cannot have the two-wheeler flings his book bag across the room, leaves the house, and returns late.

Episodes like these occur in all families. Virtually from birth, children begin to experience anger, perhaps the most powerful feeling in the repertoire of human emotions. It can surface for reasons that seem obvious — when a child clearly feels frustrated, rejected, attacked, or manipulated. Or it can appear from within for reasons that are not apparent to the outside observer.

Although all children are born with the capacity for anger, how they ultimately handle the emotion —what they end up doing with it — depends largely on learning. The stakes are considerable. The emotional and physical price for misgoverning anger can be heavy indeed, paid over the years in poor mental and physical health, flawed relationships, damaged careers, and wounded families.

Psychologists have studied expressions of anger for decades — what gives rise to the emotion, how it is expressed, and how it affects the body and mind. They and other mental-health professionals have also documented countless cases of individuals encountering difficulties in managing their anger. From the accumulated body of research and clinical information, there appear to be three major lessons that children need to learn in order to deal effectively with this explosive emotion.



Lesson 1: Anger is a natural and normal experience. Too many children grow up with the belief that they are on safe ground only if they reveal "nice" emotions like love or happiness. "Bad" emotions like anger must be hidden from view — and can be exposed only at great peril to one's security. An essential message to give children, therefore, is that we are secure in each other's love even though we sometimes reveal our angry feelings toward each other.

It is important for a child to understand that her parents and siblings are not going to become alienated from her because she expresses anger-that such expressions do not have to destroy the basic ties that bind family members to one another. The same is true where peers are concerned. Angry feelings, children must realize, need not undo our precious and enduring friendships.

It is natural enough for parents to feel threatened by the anger of a child. Especially because we feel we have sacrificed so much for our kids, we often read their rage as ingratitude. Feeling hurt, we try at all costs to shut off the anger. For the child, the result can be intolerable tension and a sense of confusion. As one twelve-year-old told me recently, "Every time I let on how angry I am, my dad acts aggravated, and I go to bed feeling I can never talk to him any more". Said another seven-year-old of his parents: "When I get angry, they just get totally upset and it ruins everything".

Our young must not be made to feel that their anger has succeeded in stigmatizing them in the eyes of the most important people in their lives-and that they stand condemned for their feelings. Through what you say and do, let your children know that the anger they reveal will not destroy your devotion and commitment.

It may help us to more willingly accept the rage of our children if we keep in mind that youngsters encounter as many anger — inducing frustrations, hurts, and disappointments as we do. Their lives, like our own, are filled with pressures to achieve and to perform. They, too, have "bosses" — parents, teachers, —who may occasionally berate them or otherwise embarrass them for no apparent reason. They also encounter insensitive or aggressive friends, missed opportunities, and crushing disappointments in life.

"...and I'm not going to take it anymore": Children must understand that violent expressions of anger like punching or cursing will not be tolerated.

"I know you feel angry, and I understand. Life just isn't always smooth or fair". Such a message lets the child know that his anger is natural and normal — an acceptable element of each of our lives.

Too often children get the opposite message entirely. "If I get angry, I get hit. Sometimes I feel like screaming inside". That observation by a seven-year-old is hardly unique. Many parents, outraged by the seemingly inappropriate anger of a child, respond with punishment. They meet fire with even more fire, aggression with even greater aggression. One ten-year-old seems to spend days on end restricted from privileges and pleasures. That is how his parents are dealing with their son's tendency to "blow up for no good reason". The results of such an approach are usually far from what parents intend.

Countless friendships and marriages have been scarred beyond repair by the tendency of one or the other party to retreat and ruminate instead of dealing honestly and directly with his feelings. The pattern often begins in the early years in homes where the lesson seems to be that the result of letting people

know you're angry always turns out to be intolerably painful.

There can be other penalties as well for constantly having to hide anger in order to avoid reprisal. Some kids become unduly scared of their parent's angry reactions. They conclude, "If my feelings cause such a storm, there must be good reason to be afraid of them." Other kids develop the tendency to overcompensate for the anger they feel. They become overly "good" —always ingratiating and yielding at considerable personal cost. Still others end up misdirecting their unspent anger at a sibling, friend, teacher, or at themselves. Among children as well as adults, hostile feelings turned inward can result in symptoms as varied as digestive complaints, constant fearfulness, or feelings of depression.

All this is not meant to suggest, of course, that children require free license to express their anger as they choose. Feeling angry is one thing, how you display it is quite another.

Lesson 2: There are both acceptable and unacceptable ways to express anger. We have all observed a hungry infant lying in his crib, bellowing and thrashing about in purple-faced rage. Or we have seen toddlers, frustrated over a goal out of reach, wail hysterically and bang away at anything in sight. In early life, the child does not yet have a repertoire of socially acceptable behaviors for displaying angry feelings, and among the results are the wild "tantrums" that most parents know all too well.

Eventually, however, children must come to understand the difference between the legitimate communication of angry feelings and hostile or violent acts. Sooner rather than later, they must get the message: The world just won't accept unbridled expressions of anger-slapping, punching, pinching, name-calling, cursing. There are standards by which humans are judged, angry or not. No family — or, indeed, any other social group — can survive uninhibited displays of aggression.

Although that conclusion seems reasonable enough, a surprising number of people, including both parents and professionals, still advocate the once-popular laissez-faire stance where children's anger is concerned. Unrestrained expressions of childhood rage, they believe, help forestall neuroses later in life. According to this view, anything short of complete emotional liberty can be psychologically ruinous for the child. Such a viewpoint, "just does not hold up based on research evidence", and has "led to some odd conclusions that are less likely to produce emotional health than emotional tyranny".

When, for example, we allow a six-year-old child to kick, or hit, or break toys, we are actually fostering aggressiveness, not helping him learn to manage anger. Indeed, what many children need most of all are clear and circumscribed limits on the expressions of anger that will be tolerated.

Such "gimmicks" can be helpful, of course. But in order to teach our children how to avoid translating anger into hostile acts, we have to provide them with a more basic and meaningful alternative: an environment in which they are encouraged to talk freely and openly about the anger they are feeling-without fear of criticism or censure. For a child to resolve angry freelings in a constructive way requires most of all being able to put those feelings into words.

It is important, therefore, for parents to encourage in the child the habit of conveying as clearly and honestly as possible the feelings that rumble within- and to be available to the child as an accepting and non-judgmental listener. One mother recently described how she was able to defuse the smoldering fury of her eight-year-old son, Mark, who felt he was unfairly bypassed for a position he wanted on the school's basketball team. For weeks, Mark returned home in a rage, and the household was ignited by his abusive sarcasm and destructiveness. The entire family-Mark, his parents, and his three siblings-were on a painful spiral of agitation and unrest.

Marks's mother ultimately recognised that no one was giving her anguished and agitated son an opportunity to testify about his intense feelings. So instead of advice or criticism, she began to offer what Mark needed most: unlimited time to talk about the inner disappointment, embarrassment, and loss of self-esteem that were stoking his unrelenting aggression. It was not long before the family storms faded and then completely disappeared.

Mark's case illustrates the fact that a child's anger is likely to fester and escalate when he is simply advised or warned, as Mark was, to "forget about it", or "turn it off". Over three decades ago, in his book Between Parent and Child (Avon Books), psychologist Haim Ginott, Ph.D., wisely observed: "Strong feelings do not vanish by being banished: they do diminish in intensity and lose their sharp edges when the listener accepts them with sympathy and understanding".

A bottom-line message that kids need to get about anger, then, is this: Talking it out to others is not only acceptable but always the better alternative to either suppressing it or being violent about it.

Mommy are poor people bad?

Teaching our children about those who have less than we have is a gradual and often very difficult process.

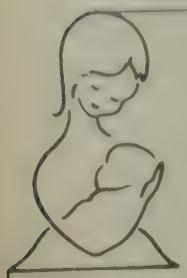
Despite our best intention, teaching our young children about the problems of poverty-about hunger and homelessness-must be one of the greatest challenges we face as parents. We want them to care about others, to count their blessings, and to be willing to share. Yet we often send them very mixed messages. For instance, there's the classic guilt trip: "Look at all the food left on your plate! Do you realize that there are some children who have nothing to eat? You just don't know how lucky you are!"

At the same time we communicate the "throwaway" ethic of the late 1980's, which leads our children to believe that almost everything can be replaced.

And then there are the powerful lessons taught by peers and television. The mother of a ten-year-old boy, remembers her child's visit to a wealthy friend, whose home was furnished with antiques, rugs, and state-of-the art electronic equipment. "Wow, they're really rich!" her son crowed on the way home in the car. His mother, who had struggled hard in order to maintain a moderate standard of living for her family, answered him quietly, "Money's not the most important thing in life". He looked straight at her and said, "Let's get real, Mom. You and I both know it is".

A less-than-perfect world

Teaching our kids about the inequalities in our society would be a whole lot easier if the world — and our own lives — were more consistent with the little homilies that we're so fond of delivering. Wouldn't it be wonderful if we could honestly present our children with a peaceful and harmonious view of our world?



But knowing that the world isn't a perfect place and that we ourselves invariably fall short of the models we'd like to be, how do we talk to our kids about social and economic realities? We don't want to confuse or frighten them, and we want to avoid being hypocritical or condescending. That's a tall order.

First of all it's important to realize that the critical factor is not your ability to deliver effective sermons on peace and justice. These abstract concepts mean little, if anything, to a young child. "Kids start becoming aware of relatively abstract notions — such as death, God, rich and poor — between the ages of three and half and four, but their understanding tends to be very incomplete," says a child-development specialist.

Virtue rewarded?

A child's notions of social justice evolve gradually and depend on both cognitive and emotional development. Throughout childhood, as the developmental psychologists explain there is an identifiable pattern of moral development. Young children believe that doing the right thing will bring rewards (which is why Santa Claus brings toys to good boys and girls). Conversely, if someone has not been rewarded, a young child will reason that person has done the wrong thing (as do many adults).

To illustrate, a parent was driving along a busy suburban thoroughfare one afternoon with a four-year-old son, and seeing a shabbily dressed man walking along the road, the son wanted to know why the man didn't have a car, and the parent told him, "because he was probably poor and didn't have a job".

"Why not?" asked the son, "Was he bad?"

Although a young child equates fairness with the beliefs and standards of his family and friends, later on he develops his own concept of justice. A child's growth reflects first his social interaction with people within his family circle and then interaction among his peers. (Charity, as the saying goes, begins at home.) The child gradually develops from an egocentric two-year-old into a social being who sees things from the perspective of others and who by the age of seven or eight learns to think in abstract, moral terms about the social order. Understanding how a homeless child feels or wanting to give to those who have less than he has will grow out of the everyday lessons in gaining perspective and sharing. This process gradually develops from a child's daily life experiences and is dependent on his cognitive development.

A gradual process

Your child will begin to feel empathy for the poor as she comes to perceive them as an extension of the human circle beyond her own family and community, says a psychologist. It is important for parents to make a point not of focusing on the differences between income and ethnic groups (which only sets up barriers) but of encouraging children to see what brings human beings together — to understand what we all have in common.

We should be aware that we inadvertently convey economic and ethnic stereotypes to our children. Unfortunately this does little to help a child empathize with people who are different.

Not surprisingly, one of the best ways to encourage your child to see those qualities we all have in common is to make sure she has personal contact with children of varied backgrounds.

Dont't blame the victim

When children who have been raised in comfort view poverty firsthand, they, like adults, are often shocked and even alienated.

Sadly, as the homeless population grows, more and more opportunities to familiarize our children with the problems of others seem to present themselves. Often it's difficult to know what to say to our children.

Many people find that coming to know those with less material wealth can be a surprisingly enriching experience. The well-off may expect to do all the giving but find that they are receiving a great deal instead. Poor people are often viewed as devoid of any richness at all. But there's more to people than their economic level. They may be economically poor but emotionally and spritually rich.

The summer holiday offers many opportunities to make efforts to make your children understand. Whether you help distribute food or toys to children

at a shelter for the homeless, why not consider bringing your child along? Such events can be informal ways for your children to get to know people whose lives are very different from their own.

Bringing the world closer

If you live in an affluent suburb, where hungry and homeless people often seem invisible, does it mean that your child will never see or learn about the other side of life? Not necessarily. There are many ways in which you can show and teach them about other people.

One way to begin bringing the world closer is by reading stories and even newspaper reports. Fairy tales have a tendency to present rich people as "good" and poor people as "bad", with fairy godmothers who can instantly transform someone from poor to rich and from sad to happy in the process. But there are a number of good children's books that avoid such stereotypes. The classic, Little Women, by Louisa May Alcott, beloved by generations of young girls, is the story of an impoverished family of daughters whose father has gone off to the civil war. It's so dreadful to be poor!" the book begins, with Meg complaining and "looking down at her old dress. "I don't think it's fair for some girls to have plenty of pretty things, and other girls nothing at all', added little Amy, with an injured sniff .

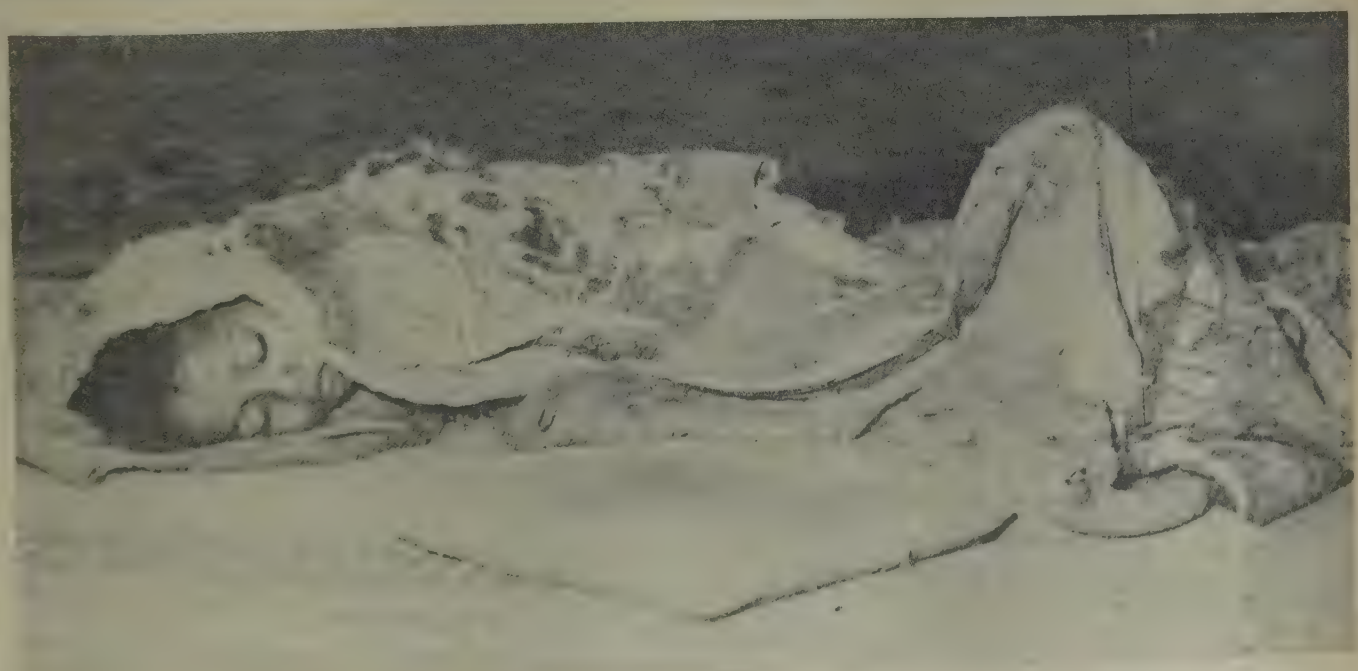
It is also a good idea to share news-paper articles or other material about the needy with your child.

"Watching the response of the child to the information he receives is critical". But what is inappropriate for one child may be perfectly suitable for another.

Give your child time

It's comforting to remember that a social conscience is developed slowly, through day-by-day encounters and experiences that span a life-time. There's no point in trying to force-feed your child or in getting alarmed when she seems to go through a period when compassion appears less important than, say, peer pressure to wear the right stone-washed denim jacket.

"We can't exceed their emotional or cognitive level. They're still in process-and so are we!" says a doctor. "With young kids all we're doing is planting seeds". If those seeds grow into a world with more caring and less hunger for the next generation, it's hard to imagine a more precious gift we can give tc our children.



Making and keeping commitments

James P. Comer

When I was twelve or thirteen years old, I sometimes made promises I didn't want to keep. On those occasions my father would always say, a man's word is his bond. For him,if you made an agreement to do something, you had an obligation to do it-no ifs, no ands,no buts.

A dying principle. I am among those who believe that there has been an insidious but significant erosion of the principle of commitment, affecting adults and young people alike. A college administrator retired early because she couldn't tolerate the attitude of too many of today's students. It troubled her that agreements to accept admission,to thank sponsors, to take certain courses, and the like were not commitments anymore. If the commitments got in the way of pleasure or a better offer, it was easily abandoned.

Come on now, you may be saying. Adults have always worried about the values and behaviour of the young and the implications for the future in every society. And the young always grow up to become mature adults who in turn worry about the next generation.

That may be so, but conditions have changed. When the sense of community was strong and adults — teachers, parents, religious and government leaders — who knew each other interacted on a regular basis, there was a built-in accountability to one another. Young people were taught directly, and learned in incidental situations, that responsible conduct came first and the quest for material gains came second. Television and other information sources did not suggest otherwise.

Some social scientists believe that, child-neglect problems, and other social concerns are related to a lowered sense of commitment to obligations. I feel that modern life is too complex to draw such simple conclusions. But it may be that we just haven't given enough attention to how and when to teach values that seemed built into the culture of yesterday.

There is growing evidence that the habits and behaviours established during pre-adolescence and early adolescence are with us for a lifetime or are difficult to change. Thus, it is an important time for parents to focus on such issues as commitment.

Parental influence

A parent's power to influence stems from modeling and acting as a mentor. If our word is our bond,we can suggest that living up to a commitment is important, and youngsters are likely to accept the notion. And yet we are not perfect. It is helpful to acknowledge shortcomings at home and in society, to strive to live up to our commitments, and to challenge our young people to do the same.

The challenge is most effective when presented in a manner that is more philosophical and reflective than demanding and directive. This approach allows youngsters to wear the shoe that fits rather than feel controlled; it promotes inner control. The next level of parental persuasion might be a discussion of the satisfaction one feels in meeting obligations or the hurt that can be inflicted on oneself and others by not meeting them. And, of course, when reflection, discussion, and cajoling don't work, it is important for us to insist that obligations be met.

Broken words

As significant as commitments are, there are times when we might forgive and even approve of our youngsters' breaking their word. After all, waxing and waning of interest is perfectly normal for kids at this age. So when your budding tennis star decides on another career — and the new tennis racquet and lessons prove to be for naught — it's really not a big deal.

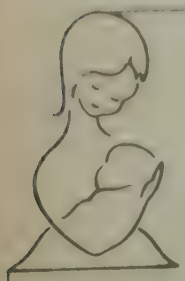
It's just as important that our young people learn not to let a sense of commitment trap them into unfair arrangements-promises made under peer pressure, for example. Perhaps one of the most useful lessons we can teach children, then, is not only to honor commitments but to think about obligations before they make them.

Disagreements about child-rearing

Lilian G Katz

It is not surprising that occasionally parents have different ideas about how to raise their child. Child rearing involves constant decisions-big ones and little ones. Should Robin start preschool? Which preschool is best? What kind of cake is best for a birthday party? The old-fashioned idea that Father knows best and therefore should have the last word has given way to greater equality of parent's roles in raising their children, and with it comes greater likelihood of bickering over the many decisions that must be made.

Effect on Kids. Research indicates that the rearing of their children is one of the main topics that couples argue about. Furthermore, studies of children's reactions to discord in the household support what many parents have long sensed intuitively: Arguments in the children's presence can be stressful for them. Recent research on infants and preschoolers also indicates that they are very sensitive to adults' moods and show marked distress in the presence of adults' anger. The degree of distress appears to be related to the intensity of adults' feelings.



Keeping the Battles to a Minimun. Even though arguments and anger seem to be inevitable aspects of contemporary family life, some steps can be taken to minimize their frequency and their potentially distressing effects on very young children. A first step is to exercise as much restraint as you can so that most of the detailed argument can be played out away from the child.

It might also be wise to set aside some time to determine precisely what the arguments are about. Are there specific issues that set off strong feelings in both parents? Developing a list of the kinds of issues that spark disagreements may help to put them in perspective. Inspection of the list may show that one or both of you are particularly sensitive to an issue that is associated with painful memories from your own childhood, and arguments may be fueled by fear that your child may suffer hurts and disappointments the same way you did. In such cases, take a close and realistic look at your child. Instead of looking for evidence that your child is suffering the way you did, look for evidence that she is managing quite well and not feeling the way you did. That should help reduce the intensity of your own reaction so that discussion between the two of you can be conducted more calmly.

Another step is to ask yourself: Is my spouse's position on the issue or behavior in the situation really harmful to our child? Think the question over long enough to consider what you really believe and what evidence you have. In most cases, careful reflection will result in the answer no. However, if you have given it serious thought and your answer is clearly "Yes, my spouse is harming our child", it seems advisable to discuss the problem with an outside person you trust — a minister, pediatrician, or family counsellor.

Total agreement isn't necessary: While bitter and acrimonious confrontations between parents can be alarming to a small child, it is really not necessary to pretend to agree with each other on all matters. Such unchanging consensus would rob a child of much that can be learned from observing how adults accommodate to differences in other's views and feelings. Furthermore, a child should not always be faced with a united front; occasionally divided ranks will encourage and stimulate a child's capacity to negotiate, bargain, and present her own case against the opinions of others.

It helps to see resolution: In addition, it is probably useful for young children to observe how adults renegotiate their relationship following a squabble or moments of hostility. These observations can reassure the child that when distance and anger come between her and members of the family, the relationship is not over but can be resumed to be enjoyed again.

Is Your Child Sad, Or Depressed?

Children, like adults, can suffer periods of depression. But how can parents tell the difference between depression as a mood state and as true psychological disorder?

★ Chronic sadness or irritability that persists for two weeks or more.

★ Boredom — while most kids experience boredom from time to time, the depressed child has lost the capacity to enjoy favorite activities.

★ Persistent pessimism or self-doubt.

★ Concentration problems, such as an inability to complete homework or tests.

★ Sleep disorders, such as waking at four each morning and not being able to fall back to sleep (this is more common in older children).

Finally, talk of suicide is a cause for concern, even if only occasionally mentioned. Although children may make idle threats to get their way. Such talk should be viewed in the context of the child's overall behavior. If warning signs do exist, parents should talk to the child's school teacher, family doctor, or a local mental health association.

Adolescence

When the child leaves babyhood behind and is entering the difficult stage of adolescence, most parents start worrying. How can parents make those trying years easier for their child? Besides the physical changes taking place in their child's body, there are those social, emotional and psychological changes that accompany them. The child is now in the transitional period of becoming an adult. And growing from childhood to adulthood can only be made easier if parents understand and help.

PUBERTY

Puberty is a process, beginning when the pituitary gland controlled by the brain, begins to release into the bloodstream increased quantities of the stimulating hormones called gonadotropins. Follicle stimulating hormone, stimulates the development of egg-containing follicles within the girl's ovaries and sperm-producing tubules in the boy's testes. Luteinizing hormone stimulates the production of oestrogen by cells within the follicles in girls and the production of androgen by cells within the testes in boys.

Most girls begin their pubertal growth spurt at around nine to ten years, most boys grow at child-rates until 11 to 12. Girls tend to be bigger than boys during these critical years and their visible breast development adds to their more mature appearance. It is not until around 14 to 15 that the boys begin to catch up. The difference in apparent maturity sometimes affects the boys' friendship with the girls in his class. Boys in early teens use exaggerated physical "showing-off" to try and assert themselves over the girls. In a family, a mature looking eleven-year-old and her still childish looking thirteen-year-old brother might find that they can't stand the sight of each other.

IN BOYS

During the first year of increased hormonal stimulation, the boy's testes enlarge but his penis and the rest of his body remain outwardly unchanged. Once the testes have matured sufficiently for sperm production to begin, their continuing growth is accompanied by rapid growth of the penis and by the first appearance of pubic and underarm hair. Around the mid-point of the pubertal process the hair increases, coarsens and becomes curly and once this stage has been reached the voice will deepen or break and some facial hair may begin to appear.

IN GIRLS

A girl's ovaries respond to the early increase in stimulating gonadotropins just as a boy's testes do

but because those ovaries are invisible, the first outward sign of a girl's sexual development will be early increase in breast size. In most girls this is very gradual. First the areolae around the nipples become more protuberant, then some breast tissue becomes visible beneath them and then very slowly the breasts fill out. In most girls the appearance of first pubic hair follows some breast development with underarm hair close behind.

MENSTRUATION

Most girls menstruate for the first time between the ages of ten and sixteen. So around 16 if your daughter has not yet menstruated, then seek medical advice.

Menstruation cannot occur until a girl's ovaries are active, once they are active, there will be signs of breast development and bodily hair. With menstruation, your little girl appears suddenly to be all grown up. She often becomes shy and withdrawn. Your daughter must be informed well in advance about what will happen. You could explain to her that there is a place in the lower part of her belly to hold the baby and nature prepares a bed of tissues and blood in her stomach and this is thrown out every month, until a girl gets pregnant. After she has a baby this process starts again every month.

Girls tend to find menstruation the most difficult change to accept, as a period is sudden while the other changes in her body are gradual. The best way to tackle her then is to treat her normally and not make an ungainly issue of it, as is the tradition in most Indian communities. In many Indian communities and in traditional families, the girl's first period is the signal for celebration and letting the whole world know. But every time afterwards when she menstruates, she is isolated and treated as unclean. As educated, intelligent, aware mothers, we must not allow this to happen. Menstruation is only a cycle in a woman's body and our daughters must never be allowed to feel unclean or isolated. Treat her with care and understanding and include her in all family activities. Allow her to go to the school picnic, if she wants to, but advise her on proper protection.

Sanitary care

In many traditional homes, women use cloth pieces as protection while menstruating. These cloth pieces are then washed and put aside until the next menstruation. This could lead to all kinds of infection. A number of mothers advise their daughters about the sanitary napkins available in the market which are disposable. These are clean and safe to use. But even the best and the most expensive specially shaped, water proof backed, keep-dry lined and soluble pads could stain underwear and clothes. So it could help if you could tell your daughter to always carry extras in her bag, as also an extra pair of panties. Most schools keep sanitary napkins in their stores, ask your daughter to find out so that she has no problem when an unpredictable period comes on.

Irregular menstruation: is very common especially during the first year after menarche. Many girls menstruate once and then do not do so again for months. Others menstruate several times in the first year but with no discernable pattern. Ensure that your daughter has sanitary protection available both at home and at school and make it clear that there is no cause for concern.

Pre-menstrual tension: Irritability, depression, cramps and heavy aching of body results in pre-menstrual tension, which is worrying. But many girls, just past menarche, do not ovulate and they may have periods for more than a year before ovulation becomes regular. And pre-menstrual tension is generally linked to menstrual cycles in which ovulation takes place. So you can assure your daughter that her early periods would be trouble-free. While pre-menstrual tension and period pains are real, they are certainly affected by expectations and emotions. If your daughter assumes that her periods will be unpleasant she is far more likely to experience them as such, so if you treat her normally she will take it in her stride. Don't tell her that it is a woman's lot and that if she can't bear this suffering how would she bear other suffering later on in her life, a myth that most Indian mothers take pride in passing on to their daughters. And if she does get cramps or headaches, treat her just as you would when she has headaches at other times. Give her an aspirin or pain-killer, but don't let her conclude that she is going to be off-colour for all the 3-4 days. If she can take each period calmly, she will be able to give her body more chance of adapting smoothly.

EARLY OR LATE PUBERTY

Most adolescents rely heavily on the support of

their friends while they fight their way up from childhood. The child who must undergo conspicuous physical changes before most of his friends, or who gets left behind as others develop, tends to feel isolated. On the whole boys find it easier to accept early physical growth rather than delay. To be the largest in the class is usually a plus where a being a boy among young men is a minus. Yet it can be very embarrassing to tower over friends and to be unable to trust one's voice not to break suddenly while answering a teacher.

For girls early growth in height is embarrassing, not only is she suddenly taller than her friends, she is also taller than boys of the same age. Early breast development can also be embarrassing making the girl feel clumsy and heavy. Girls who remain child-sized and child-shaped while friends are changing may be equally distressed. Parents could help by letting them know that the wide range of normal development is common and nothing to worry about. That while he or she is growing too fast or too slow,there is still a lot of time to catch up with the others.

THE DIFFICULT ADOLESCENT:

The teens from 13 to 19 is a stage of development, when your child is constantly growing and changing. This is the time when he or she prefers peer company to the company of parents. You may find that your little one who was totally dependent on you for everything, does not need you as much as before. He or she is impatient, irritable, angry and arrogant. This is when you find that there are many things your son or daughter is not telling you and keeps his or her "very own secrets".

Instead of probing or being inquisitive, maybe you could try leaving them alone yet letting them know that you are always around to help if necessary. State your ground rules, let them know how far you will tolerate their new found freedom and how far they can stretch their wings. Let them know about sex and making babies and let your daughter know that she could get pregnant. Warn them of the evils of smoking, drinking and drugs and hope that your child's basic integrity will see him or her through these difficult years.

However difficult or rebellious your son or daughter is, remember that this stage of life is a developing stage and that your son or daughter will grow out of it. This is the same person whom you loved as a baby and enjoyed as a child so don't be quick to label him or her as a rebel. **— JM**

When Kids Tell Lies

Julius and Zelda Segal

"I saw a cobra on my way home from school. Honest, I did". "Believe it or not, I answered every question right that the teacher asked me". "No, I swear I didn't touch that money in the drawer".

All of the above statements were made by five and six-year-olds, and, strictly speaking, all of them are lies. But they are in fact vastly different, reflecting the varied motivations that give rise to the telling of untruths by children.

For the first child, the motivation was the need to win attention by startling his listeners with an outlandish tale. Some children tell untruths because they feel ignored; many a childish fish story is nothing more than a message to parents: "Please notice me".

For the second, it was the yearning for parental approval. Children may fictionalize their activities because it helps them heal a bruised self-concept and avoid the intolerable possibility of rejection when they fail to meet a parent's standards.

For the third, it was fear of dire punishment. In more households than we might imagine, harsh and repressive discipline — including physical punishment — leads to lying as an escape and evasion tactic.

Clearly, the most sensible response to a child's lying must depend on an understanding of its roots. Here, however, are some general guidelines to keep in mind.

Don't confuse a fertile imagination with lying

Like younger children, some five-year-olds make up stories from time to time, but they are not lying in the conventional sense. Their tales are the products of imaginations working overtime. A sensible response avoids confronting or demeaning the child but still acknowledges the fiction. "Hey, that's a great story you made up," says one father to his son, as if the lad were tomorrow's greatest novelist. "Let's write it down and read it to Mom tonight".

Pay attention to the behavior that is being lied about.

Lies are sometimes clues to trouble spots. Especially if they form a pattern, they can be a tip-off about a problem in the child's world that she is trying to deal with by lying. Is the child reshuffling the facts about school performance? Perhaps her self-esteem is eroding under the onslaught of the impossible first-grade expectations of her teacher and parents. Try to look beyond the child's stories to their emotional roots. What is so intolerable and anxiety-provoking about the child's world that she needs to flee into the unreal?

Revaluate your disciplinary tactics.

Some parents literally encourage their children to lie by meting out excessively severe punishments for "wrongdoing". If you were certain you would face solitary confinement as a consequence of your midnight raid on the refrigerator, would you gladly come clean when interrogated by your spouse about the missing food? The analogy is not as farfetched as it may sound. Countless children, made to feel threatened and defensive over even minor infractions, are propelled into a pattern of lying simply to escape unduly harsh reprisals.

Avoid a double standard

Your best efforts to teach honesty are likely to do little good if you end up being observed telling untruths yourself. If, for example, your son hears you tell a caller on the phone, "No, he isn't at home right now", when Dad is sitting right there at dinner, you are hardly in a strong position later that evening to be preaching sermons on truthfulness. For the young child, your own "white" lies of convenience are impossible to differentiate from his own "sinful" ones.

In the final analysis, it is an underlying feeling of mutual regard between parent and child that is the best inoculation against telling lies. In homes marked by confidence and trust rather than suspicion and fear, truthfulness is likely to be the prevailing currency of parent-child relationships.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad - 500 003. Ph: 841610

Assert yourself

Patricia D Perry

Does your tendency to care and cooperate lead others — even your family and friends — to take advantage of you?

Then it's definitely time to learn to Assert yourself!

Quick Quiz

Is it easier for you to clean up yourself than to keep pushing your children to do so?

Yes ☐ No ☐

If your husband comes home exhausted and makes no move to help with the kids or supper,do you do everything even though you are exhausted,too

Yes ☐ No ☐

If your child's teacher says she doesn't have time to do extra work with him as she promised,do you accept her decision?

Yes ☐ No ☐

If your father-in-law says something sarcastic about boys who prefer painting to sports in front of your artistically oriented son,do you keep quiet?

Yes ☐ No ☐

If you have answered yes more often than no, you may have trouble being assertive. I know, as you read these scenarios, you have a million rationalizations: "It's easier," "It's foolish to make such a big deal of a little thing". While all of these internal arguments may, in fact, be valid, and at times you may decide to say yes when you want to say no, the key element is that of choice. It is not a true choice to say yes because you are afraid to say no.

What makes it so hard for women to deal with these kinds of situations? There are many different explanations that have been offered over the last ten years, the most compelling of which focus on the role of socialization in forming a woman's personality. For many women who are now mothers,the messages they received growing up instructed them to be modest, humble, unselfish; yet when they tried out this "proper" behavior, they often were taken advantage of and belittled. But rather than getting angry at others, women tended to see themselves as "too sensitive," "overly emotional," and "over-protective," labels which led to even more passive behavior.

Feminism's call to throw over all these old messages created a new turmoil for many women. They were told to change from quiet and passive to loud and aggressive. While women enjoyed the freedom to speak out, it soon became a burden as they found themselves alienated from friends, relatives, and spouses. Something did not feel right.

What does this mean for women who are trying to be assertive? Often it means that saying what they really think violates their Morality of Care and often leads women to rationalize why they should not speak up. If I scold a neighbor's child, her mother might not like me anymore. If I fight a problem in the school system, I might be labeled a troublemaker and my children will suffer".

It is a real double bind. Helping one person or oneself might lead to conflict with or pain for another. Often silence seems to be the only way out, especially when the person who loses is the mother herself. Better that she be miserable than that anyone else be unhappy. At least that feeling is familiar!

So what can a mother do to become more assertive without compromising her values? First, it is important to understand the differences between nonassertiveness, assertiveness and aggressiveness, because women frequently confuse the last two.

Nonassertiveness: Saying less than you would like to express and denying your own rights.

Aggressiveness: Standing up for your rights that in a way violates the rights of others.

Assertiveness: Communicating in a way that takes

into account your own rights, needs, and feelings and does not violate the rights of others.

In other words, being assertive does not mean walking all over people to get what you want! Being assertive must also mean being caring, empathic, and cooperative.

What do the differences sound like? Say your friend has started dropping in to talk on an increasing regular basis. You are finding it hard to get your work done because she stays so long. An aggressive retort would sound like this: stop whining! It's time you pulled yourself together. I have things to do, you know this of course, gets the point across that your friend is wearing out her welcome, but you may also lose a friend. A nonassertive response would sound like this "It's really hard for me to get everything done these days. Sometimes I think maybe if we did not talk quite so much that I could get more done. It's probably my fault. I'm just so unorganized. In an effort to be gentle, you undid yourself by backing down and blaming youself. Here's how to be both gentle and firm and still assert yourself. "I realize you have an awful lot on your mind, and I'd like to help you, but I feel resentful because I can't get my work done. Could we figure out a way to give us both the time we need?". This lets your friend know you care and want to help her, but that you also need to set some limits.

Women also have difficulties speaking freely to their husbands. The fear of anger and conflict may immobilize them. Yet women can learn to communicate in their marriages in ways that will help both partners feel better; and the parents' successful negotiations provide important role models for their children in conflict resolution.

Imagine that your husband announces that he is going out with a friend on Saturday instead of going out with the family as originally planned. What do you say? Your reluctance to upset your husband may lead you to say something like this: Oh. (Long pause). I had thought we were going to the beach. I mean, if you really want to, I suppose, I don't know. The kids were looking forward to it... This doesn't really say what you feel. Or you may just explode with anger: I should have known! Every time we plan something,you mess it up. But this doesn't get across what you really want. Better to acknowledge your husband's disappointment, giving him a positive alternative but still standing up for what you had planned: I can understand how much you'd like to go but we agreed we were going together, and we've all been looking forward to it. Can you two set another day?

While these kinds of answers may look clear and obvious on paper,they rarely are when you're stuck in the middle of a dilemma. At those times, rationality goes and all of one's irrational thinking takes over. Women, I have found, have a tremendous power to visualize multiple terrible outcomes to any given situation. What all mothers fear on some level is that their children (or their friends or spouses) will not love them if they say no, or push too hard, or set too many limits.

For example, it can be very difficult to say no to a child who is pleading to do something with all her friends when you want her to go to a special family gathering instead. What might go on in your mind is a monologue like this: Oh no if I tell her she can't go, she'll hate me. And maybe nobody will ever ask her to do anything again and she'll blame me for that. Besides, I can imagine how horrible she'll be at the party. In a few short moments, you will have talked yourself out of doing what you wanted to do.

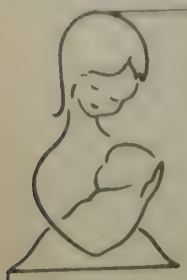
Part of being assertive is learning to give yourself a rational pep talk. Instead of saying the above to yourself, you might say: "If I say no, she'll be angry, but I believe it is important for her to be at this party. I also know that even if she gets mad at me, I will survive her anger and we can work it out". Not surprisingly, this sensible, loving limit setting is the primary deterrent to serious misbehavior in children and adolescents.

It is important to note that "loving" limit setting. By that it means that "assertive", not "aggressive", discipline. You ignore the mess on the family-room floor for three quarters of the day because you are hoping your children's "better instincts" will finally take over and they will clean it up. Suppertime arrives, the mess is still there, and you start shrieking

that they don't care about you or how the house looks and then you promptly ground them for the rest of the week.

Next time, start earlier, while you are still calm. At lunchtime, say: "I notice there is quite a mess on the floor. I would like it cleaned up by four o'clock". If at three or three-thirty there are still no signs of cleaning up, you can escalate, saying: "I don't want to have a yelling match about the mess. If it's not cleaned up by four, you will not be able to have any friends over tomorrow". At four o'clock you go to them and say: "I'm sorry it had to be carried this far. Clean up everything now and no friends tomorrow!". While your children may lose their tempers at this point, try not to lose yours. You will almost always feel worse if you do.

Trying to become more assertive is hard work. For that reason, a mother has to believe that what she is doing is right, and it is right. It is caring to set limits. It is good modeling to protect one's own rights as well as the rights of others. It is loving to respect another person enough to ask for his or her best behavior. Finally, it is not only very courageous but also very assertive to be willing to examine, acknowledge, and improve the parts of yourself that are most difficult to change.



Developmental and Behaviour Problems

Dr Shoba Srinath

Besides routine problems like infections, children can also have developmental and behaviour problems. The latter two are discussed below:

Developmental problems are those disturbances occuring as the child's process of development unfolds. These may be delays or distortions in development.

a) Delayed general development — mental retardation — Anil, a six-year-old born of normal delivery has had a delay in all his milestones. He crawled, stood and walked late, he babbled and started talking late and currently he is functioning like a three-year-old. This child needs a lot of training if he has to improve.

b) Disturbances in vision and hearing: Children who are otherwise intelligent may have problems with their eyes and ears and this interferes with their development.

c) Learning difficulties: There are some children who are backward only in school-related skills like reading, writing spellings and mathematics. These children are otherwise smart and intelligent. They need specific remedial education to overcome this problem.

d) Communication disorder: Srilata is a four-year-old, who seems to understand most of what is told to her but does not have the ability to answer and talk like a four-year-old. Her other development has been normal. She has a specific expressive speech disorder.

Lokesh a six-year-old on the other hand can speak as he should, but cannot pronounce the sound 'R' but instead says 'La'. This is an articulation problem. Both the above children can be helped with speech therapy.

Behaviour problems are those abnormalities of behaviour which occur repeatedly, are severe, last for a longer time and seem to come in the way of adequate functioning of the child, his family or his environment. They may be of different types:

a) Conduct disturbances: Raju, a ten-year-old, has started stealing money from home repeatedly and has recently stolen Rs.50/- from a guest of their house. He has also been running away from school and returning home on time, lying about the stolen money and about examination marks. All this has happened over one year.

Shashi, a nine-year-old, is very disobedient and stubborn at home. It sometimes gets so bad that the parents have to severely beat him. Occasionally, he beats up his sister in anger.

Both these children are displaying conduct disturbances and the family needs help from their teachers and doctors.

b) Emotional disorder: These children have features such as being excessively shy, anxious, worrying too much, being more fearful than usual, being far more low and depressed than is expected of youngsters.

Celia, a nine-year-old, has become dull and quiet than usual since about six months. Her studies have suffered and her teachers were the first to note the disturbance. She has no physical problem.

Govind, a twelve-year-old, has repeated trouble in going to school. He gets very anxious, and cries saying he is afraid to go away to his day school. He is an average student with no particular trouble in his class.

These children have an emotional problem and the family needs to seek guidance. There are several other disturbances that can occur in children, like psychoses. These are serious mental disorders in which the child does not eat or sleep properly, talks irrelevantly and is disturbed. He does not seem to be aware of his surroundings. Such a child needs urgent help.

One finally needs to remember that a number of so-called physical illnesses are influenced by the mental/psychological mechanism.

Health Action — a national monthly magazine of HAFA, P. Box 2153, 157/6, Staff Road, Gunrock Enclave, Secunderabad-500 003. Ph: 841610

Compassionate kids

Altruism does come naturally to children, but it's a trait that needs to be encouraged and nurtured in order to blossom.

★ ***Thirteen-month-old Suman is eagerly devouring his supper when his weary dad returns from work and slumps into a chair. Suman shifts his attention to his tired daddy and begins feeding him the remaining food.***

★ ***Two-year-old David accidentally hits a playmate on the head. He looks stricken and immediately kisses and consoles her. "I hurt your hair," he says. "Please don't cry."***

★ ***Smitha, 21 months, notices that her mother is distraught after a squabble with her husband. Smitha climbs onto Mom's lap and begins to offer comfort-kissing her forehead, and saying "Hi" repeatedly until she gets a "Hi" and a smile in return.***

These three episodes are among many similar ones reported by people, who have studied children's altruistic behavior — that is, behavior intended to help someone in need. These three children are neither angels descended to earth nor aberrations of human nature. Even babies as young as one-year-old display surprisingly generous instincts, often performing acts of genuine compassion. Contrary to both popular and professional wisdom, our young begin life not as totally selfish little creatures but with an amazingly well-developed sense of caring.

Not that children are without a darker side, of course. As parents know, all kids can be narcissistic and hostile as well. As in adults, egotism can coexist with altruism, self-indulgence with self-sacrifice. Parents should ask themselves, "What can we do to encourage the positive side of our child's nature? How can we nurture the apparently instinctive feelings of concern that youngsters have for people around them?" Findings from various studies suggest seven steps to help our young grow into more caring, compassionate, and generous individuals, sensitive to the needs of others.

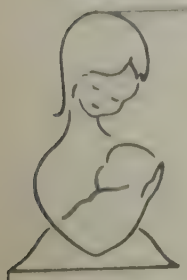
Let your children know how deeply you feel about their behavior toward others. Theoretical discussions about human kindness, are not as likely to encourage altruism as is stressing its importance to you as a parent. In my home as a child I learned that I was being judged as much by the way I dealt with my friends as by the report card I brought home from my teacher. Mother never learned the rules of baseball, but she was certain of the rules of life. From her perch at the kitchen window, she would watch our games unfold, and if one of us mistreated another, her reaction to our behavior would be swift and unambiguous. If we acted mean, we were in serious trouble.

Today's researchers are finding that my mother's instincts were exactly right.There should be nothing tentative about a message to little ones who seem to be developing a "me first" approach to life. A mother must let them know, in no uncertain terms, exactly where she stands on the important issue of human kindness.

Evidently children learn more readily to care about others when it is obvious that their caring means the world to their parents. Let it be heard from the mountaintop how much kindness and consideration mean to you.

Make sure that your child understands why caring counts. Emotional displays alone are not enough. Fostering altruism requires also that parents convey the reasons for the importance they place on helping others. This means taking the time to explain with-"high intensity and clarity" — the consequences of our behavior toward others.

Let's face it. There are sure to be occasions when raw self-interest overwhelms the best instincts of even the most generous child. At such times, studies



show, children need to hear an authoritative voice describe what the fallout is likely to be for the other person. For example: "Now look what you've done! Suman is crying because you won't share the candy," or "What you said was awfully mean! Sumitha is unhappy because you hurt her feelings".

Parents who consistently respond to the self-serving behavior of their young in this way tend to encourage the development of empathy — the capacity to feel the joys and sorrows of others as if they were one's own. This readiness to identify with the "victim" is crucial. At any age, we are most likely to behave altruistically only if we have learned to feel personally connected to others.

Don't just preach; practice. When my friends and I were young children, we used to see our elders regularly empty their carefully saved pennies from a "charity box" and offer them to anyone who came to the door seeking help. My own father's ability to pay the next month's rent was chronically in doubt but never his readiness to reach out to people he viewed as "even worse off than I am ." Such acts set tangible standards for children. They fix in the soul a posture of caring.

If parents behave in charitable ways, so will their child — even if they have preached greed. Where there is a gap between the sermons of parents and their actions, children will model themselves from the living examples they observe rather than the words they hear. In childhood, caring is caught rather than taught.

Acts of caring must be firmly embedded in the family's routine. Children are likely to behave altruistically if their parents have been consistently active in giving and caring themselves.. "Just as many schools now train superb drum corps, they could also train "caring corps" — groups of young men and women who would be on call to handle a variety of emergencies'.."

There is evidence that youngsters tend to emulate models of caring even when they only observe them on T.V. Children who watch altruistic behavior on television become more altruistic themselves. Studies show that just as the viewing of violent acts on TV can stimulate aggressive behavior, the viewing of "prosocial" acts can encourage such behavior as sharing, helping, comforting, and protecting others.

Books can be helpful, too-although, it is surprisingly difficult to find books for children that trumpet altruistic behavior.

Such stories are important for today's youngsters to learn about, especially as they approach adolescence. They extol the careers of men and women who were truly committed to caring — the kind of charismatic figures that my schoolmates and I kept hearing about as kids, but that are not so frequently heralded in contemporary society. Children today are constantly being made aware of countless people who are "famous" on TV and in magazines. But the line between deserved fame and earned notoriety is getting harder to decipher all the time. It is no longer easy for youngsters to pick out the "good guys" from the rest of the pack.

Be on the lookout for opportunities to introduce your children to figures who exemplify caring, and encourage their feelings of identification with them. Talk admiringly about the people you look up to as models of generosity and compassion. Expose them to stories of heroes of the spirit as well as those of science, sports, and the cinema. There's no reason why Mother Teresa or Martin Luther King Jr. can't be as exalted as such stars as Madonna or Michael Jackson.

Reward your child for acts of caring. That's not always as easy as it sounds. It's a lot easier to get caught up with the problems that the child is causing rather than the good the child is doing. We do not typically respond to the prosocial acts of children with the intense emotion that we display in the face of their temper tantrums, for example, or their disobedience. The humane and magnanimous acts of the young often pass unnoticed.

It is wise, to be ever on the lookout for signs of caring, and when you find them, to recognize and applaud them. Even a generally self-involved child will on occasion act with a surprising degree of consideration for others. The parent's task is to spot a child in the performance of altruistic deeds and then to provide reinforcement. For example, a father

might say: "I saw you take care of the boy who fell on the playground. That was very kind of you, and it makes me feel proud." Or, "You did a marvelous thing when you offered that woman on crutches your place in the movie line". Children need to be told over and over of the intense pleasure and pride we feel when they have dealt compassionately with others.

Help generate opportunities to practice caring. Compassionate behavior can often lead to compassionate attitudes, rather than the other way around. Benevolent acts often produce feelings of satisfaction and fulfillment that are, in themselves, powerful reinforcers. Children need to feel the special glow of satisfaction that follows when we encourage them to carry food to an ailing neighbor, for example, or scribble a letter of comfort to a sick classmate. The practice of caring usually brings with it its own built-in psychic rewards.

Schools can play a critical role in facilitating altruistic acts by building into their programmes a "curriculum for caring". Through it, students would not simply learn about the concept of kindness; they would actually engage in its practice. They would spend time helping to care for younger children, the elderly, the sick, and the lonely in nursing homes and day-care centers.

If a parent fell suddenly ill, these students could come into the home to care for the children, prepare meals, run errands, and serve as an effective source of support for their fellow human beings. Caring is surely an essential aspect of education in a free society; yet we have almost completely neglected it.

Some parents may feel inhibited about exposing their youngsters in this way to the stark realities of human distress for fear that they will be unduly upset or even traumatized by the experience. I'm not so sure I want my child burdened by the agonies of others, one mother said to me recently. There's plenty of time later on for that.

Build a bridge of caring between yourself and your child. Among the many touching vignettes recorded by researchers studying children's altruism is the following response of a four-year-old upon hearing of the death of a friend's mother. "You know, when Bonnie grows up, people will ask her who her mother was, and she will have to say 'I don't know'. You know, it makes tears come in my eyes".

What inspires a child to grow up caring about the fate of others in such an empathic ways ?

The child's zeal to practice altruism may well depend on the existence of a solid and nurturing bond between parent and child. It is from such a secure base that youngsters are more likely to venture forth and pay attention to others rather than to be chronically preoccupied with their own ungratified needs and desires. When you are a child still struggling to evoke the caring and commitment of hopelessly remote parent, you are not likely to have much psychic energy left to think selflessly about those around you.

There is another reason why nurturing parents tend to rear altruistic children. The nurturance offered by parents to their children is itself a perfect model. When children are the beneficiaries of our own acts of caring — self-sacrifice in the face of their needs, compassion when they are in pain, forbearance in the face of their mistakes — they are likely to behave in the same ways toward others.

Indeed, it is likely that one of the approaches suggested in this article will work in the absence of an indestructible link of caring between parent and child. To grow and flower, the seeds of altruism within each child need most of all the nourishment of our own abiding love.

And Check It Twice

Taking your infant or child to the doctor, whether it's for a checkup or for checking out symptoms, can be a harrowing experience. It's easy for a parent to get distracted by the child's need to be comforted and reassured. That's why it's a good idea to make a list beforehand of concerns you want to discuss with the doctor. Sit down and write it during some quiet time; if you don't have any, begin a list, keep it, someplace handy, and add to it as the concerns and questions come to mind. This way, you won't remember them on the way home or be annoyed with your child for making you forget".

— Parents

Health Quiz

N C Jain

How about testing your skills in a spot health quiz? Go ahead have fun. For section A, mark two points for every correct answer and for section B one point for each correct answer. Check your tally at the end of the quiz to see how you fared.

Teachers and parents, you can use this quiz to test your children on the all important knowledge of health.

SECTION A

I Tick the correct answer:

1. Malaria is caused by the bite of

a) female anopheles mosquito
b) male anopheles mosquito
c) Plasmodium
d) tapeworm

2. Night blindness is caused by

a) lack of vitamin B complex
b) lack of vitamin A
c) lack of calcium
d) excess of calcium

3. Cigarete smoking produces all the following diseases except

a) heart attack
b) cancer of lung
c) cancer of stomach
d) diabetes

4. Child with diarrhoea

a) should be given water
b) should be given water and salt
c) should be given water, salt and sugar
d) should not be given anything to drink

5. Which of these pigements makes hair black

a) Haemoglobin
b) Melanin
c) B-carotene
d) None of the above

6. Dermatology, gerology, oncology and otolaryngology deals respectively with

a) old age, ENT, skin and cancer
b) skin, old age, cancer and ENT
c) ENT, cancer, skin and old age
d) cancer, skin, ENT and old age

7. The science of human beauty is

a) karyology
b) kalology
c) cosmology
d) none of the above

8. National Health Policy of the Government of India was announced in

a) 1980
b) 1981
c) 1982
d) 1983

9. AIDS (acquired immuno deficiency syndrome) is caused by

a) bacteria
b) fungus
c) parasite
d) virus

10. The smallest bone in the human body is

a) incus
b) malus
c) stapes
d) none of the above

11. Which of the following is not a disorder of the eyes

a) trachoma
b) glaucoma
c) epilepsy
d) conjunctivitis

12. DPT Vaccines immunizes against three killer diseases of the childhood viz., diphtheria, tetanus and

a) poliomyelitis
b) whooping cough
c) pneumonia
d) measles

13. Goiter is caused by the deficiency of which element in the diet ?

a) Iodine
b) Fluorine
c) Calcium
d) Iron

14. The tsetse fly is the vector for

a) filaria
b) malaria
c) sleeping sickness
d) dengue

15. Where do you find the islets of Langerhans?

a) Spleen
b) Pancreas
c) Colon
d) Liver

SECTION B

I Match the column:

1. Match the following biomedical institutes (A) with their place of location (B)

A	B
i) Institute of Cytology & Preventive Oncology	(a) Bangalore
ii) National Institute of Mental Helath & Neuro Sciences	(b) Ahmedabad
iii) Malaria Research Centre	(c) Lucknow
iv) National institute of Nutrition	(d) Madras
v) Tuberculosis Research Centre	(e) Calcutta
vi) National Medical Library	(f) Agra
vii) National Institute of Immunology	(g) Delhi/ New Delhi
viii) Central Jalma Institute for Leprosy	(h) Hyderabad
ix) National Institute for Cholera and Enteric Diseases	
x) National Institute of Health & Family Welfare	
xi) Central Drug Research Institute	
xii) National Institute of Occupational Health	

II Match the following days (A) with their exact date (B)

A	B
i) World Health Day	(a) April 7
ii) World AIDS Day	(b) December 1
iii) International Day against Drug Abuse & Illicit Trafficking	(c) June 26
iv) World Environment Day	(d) June 5
v) National science Day	(e) February 28

Answers to the Health Quiz

SECTION A:
1.(a), 2.(b), 3(d), 4.(c), 5.(b), 6.(b), 7.(b), 8.(c), 9.(d), 10.(c), 11.(c), 12.(b), 13.(a), 14. (c), 15. (b),

SECTION B
I
(i)-(g), (ii)-(a), (iii)-(g), (iv)-(h), (v)-(d), (vi)-(g), (vii)-(g), (viii)-(f), (ix)-(e), (x)-(g), (xi)-(c), (xii)-(b),

II
(i)-(a), (ii)-(b), (iii)-(c), (iv)-(d), (v)-(e).

SCORING:

Section A

25–30 — Excellent
Your awareness and knowledge of health is mind-boggling.

20–25 — Good
You are fairly concerned about health but have not really stirred yourself to know more.

Below 20 — Poor
You have not bothered about keeping your body and soul together.

Section B

12–17 — Excellent

8–12 — Good

Below 8 — Poor

Is fun food good for your children?

Aneeta Shah

Did you see a Superman flying in Bombay's sky recently? He's a part of a well-planned out advertising campaign to sell Peppy Crispies, a ready-to-eat hi-protein snack.

But is it really as nutritious as is made out to be? How do the manufacturers S.M. Foods, a division of S.M. Dyechem, Bombay, substantiate their claims?

To start with how does one evaluate a hi-protein product?

According to the Institute of Nutrition, Hyderabad, young children between ages one and three need 21 gm of protein daily, the four to six-year-olds need 26 gms; the seven to nine-year-old require 33 gms and for 10 to 14-year-old children 43 gms is sufficient.

The four to six-year-olds are maximum consumers of such fun foods. This target group's protein intake therefore makes it an excellent study group.

By way of marketing, Peppy's print ad cleverly compares proteins from other foods on a 100 gm intake scale. For example, milk, they say, gives 3.3 gm of protein compared to Peppy's eight gm. But let's stop and think. A four to six-year-old drinks 400 ml (about two glasses) of milk daily, giving him 13.2 gm protein. While a single Peppy pack (40 gm) would give him merely 3.1 gm!

Comments pediatrician Dr M Balsekar, "I don't endorse (the product) because those who can afford this high priced protein don't need it and the people who do need it can't afford it. Just one rupee worth of a simple food like peanuts provides 6.5 gm protein!". In comparison Peppy, at Rs 4 a pack, is by no means cheap.

Jack 'n' Jill Merri Rings is made by Glindia, Bombay, which has slotted the product as a breakfast cereal to be added to milk. It is labelled a pharmaceutical product, with iron, vitamins and six gm protein per serving, just two gm short of Peppy. Product manager Mr Silvan states, " I wouldn't like to comment on Peppy being hi-protein or not".

Another fun food manufacturer is Gajraj Foods Pvt.Ltd., Bombay, makers of Daddy's ready-to-eat potato sticks. Comments product manager Mr Bhatnagar, "I would not consider Peppy as hi-protein. You would have to consume at least five packs daily for any nutritional benefit".

Axis Advertising has effectively spent Rs. 30 lakh. Comments Krishnan, "The idea is Superman bringing a protein food. The packaging and marketing have been tremendously successful, beyond our imagination".

Answers Mr N. Krishnan, marketing manager, S.M. Foods, "Children today crave for these fun foods, chocolates, wafers, sweets. We give them some thing more than calories. We give a nutritious protein food that is fun as well as, overcomes the parent's anxiety about junk food".

Peppy is made from soya flour, the richest source of protein. The reference book on nutrition released by the Institute in Hyderabad says, "Proteins supply the building material for the body. Among vegetarian foods, pulses and nuts often exceed (in protein content) those present in animal foods. Soyabean is unique in this respect containing over 40 per cent protein".

Dr Kuchni, food technologist and chief executive of Shree Foods, which makes Schnappers ready-to-fry crispies, adds, "Soya proteins are more digestible than others. They are also close to milk proteins. But this does not disqualify other foods, say, wheat flour. "If a child's daily nutritional requirement is 26 gm, 3.1 gm is not hi-protein. But as a fun food snack it's okay". Adds Mr Krishnan, "No other crispie provides 3.1 gm soya protein in a 40 gm pack. Definitely, Peppy is hi-protein".

Pressures on today's youth

Dr. Lata Hemchand

The world today is on the threshold of a second and more important stage of the industrial revolution the phase of its social implementation. The advanced nations of the world are providing for a reassessment of public education in a manner as to assist this social change. This change has been reflected on the Indian scene too, perhaps more intensely than anywhere else because our social-educational system has not been geared for this change. It is the college youth who are most susceptible to this change and hence undergo intense mental turmoil in coming to terms with it.

"Our generation has no ideology", "we have learned that there are no absolute rules", "we make rules ourselves", "what am I doing here? I am not learning anything" were some of the comments made by the youth of Berkley University during the famous students' rebellion of 1964 - probably the first of its kind. These statements made almost two decades ago, are equally relevant for today's college youth. In fact in the present day Indian context with the rapid breakdown of traditional values, and technological changes, the Indian youth is facing intense pressures.

Emotional Stress

In understanding the emotional state of college youth today, we have to keep in mind the transitional socio-economic-cultural scene on the one hand and the uniqueness of the development tasks which exposes the young for the first time to a combination of experiences — need of physical fullfilment, a freedom to experiment with new ideas, to develop interpersonal relationship with peers and other adults and to achieve competence in work. It has been recognised that at no period of development is there such a need to cope with conflicting pressures and to organise inner and outer realities. It is an interplay of these developmental tasks of youth with the complex socio-cultural structure, that is known to be behind the high incidence of emotional disturbance among youth.

The prevalence rates of mental morbidity among college students have shown a rapid increase from 5% to 10% in 1960's to 40% to 60% in the late 70's. The prevalence rates quoted here are mainly from research done abroad. The awareness and concern over mental health problem of Indian college youth is of recent origin. Probably only since the last one decade have researchers focused their attention on this issue. The results, of these studies indicate that 20% to 60% of Indian college students suffer from emotional disturbances of varying intensity.

I had conducted a study on 354 graduate students of Bangalore University during the years 1980 – 82. The aim was to screen the emotionally disturbed students and to see the effect of counselling them. Results indicated that 65.25% of the students needed professional help and guidance for their problems. The counselling process was a heartening experience since most of them showed positive changes towards better adjustment.

Table below shows the various types of problems that were studied and the proportion of students suffering them.

Problem areas	Percentage of students with problems
1 Bodily complaints	93.78
2 Educational (difficulty in concentration, poor study habits – teacher student relationship)	79.09
3 Negative self-image	83.89
4 Social submissiveness	66.38
5 Feelings of inferiority	65.53
6 Emotional disturbance	65.25
7 Family interpersonal relationships	63.55
8 Hypersensitivity	57.06
9 Custom, morality and religion	56.77
10 Friendship, sex and marriage	54.80
11 Economic	54.23
12 Anger	53.10
13 Tension	49.15
14 Vocational	48.87
15 Anxiety	35.87
16 Depression	30.50

Age related problems

If we were to compare the symptoms of psychiatric patients in a general hospital with those of the student population, the bulk of the symptoms in both settings would fall under somatization or bodily complaints. However, the other problems of college youth such as developing a better self-image, difficulty in concentration, developing a value system, conflicts in friendship, sex and marriage are all distinctively age related. In other words, young adulthood is a phase of development where the youth has to cope with conflicting pressures of biological needs, morality and values, family and social interpersonal relationships and finally work or professional achievement. The experience of most student counsellors abroad as well as the author's own experience confirms that the problems of the college youth are age-related and hence transient. If they are given professional help during this critical phase it would prevent later psychiatric problems.

It is unfortunate that Indian Universities have not taken cognizance of the enormity of mental health problems among students and only a couple of them have student counselling services. Student "alienation", "apathy", "identity crisis", and "anomie" are some of the problems faced by the college intelligentia which if given help and guidance could evolve the student into a healthy, self-actualizing individual making positive contributions to the society. But the same problems untreated often become the basis of drug addictions or neurotic problems in later life.

Drug Addiction

College campuses are rampant with drug addicts but very little has been done to understand what mental attitude or emotional state of the student gives rise to this destructive habit. Establishing better student counselling facilities would be a major step taken towards primary prevention of mental illness and drug addiction.

In conclusion I would like to quote the operational definition of a mentally healthy person as declared in the International Conference on student mental health at Prince University, New Jersey. — "The mentally healthy person is one who is developing towards personal maturity. Maturity is reached in the same degree as the individual can independently and in a fruitful way overcome his internal conflicts, realise his own aims in life and responsibly live in fellowship with others".

Parents Are You Listening?

Susan Goodman

Children should be seen *and* heard. You may be tuning out the hidden messages behind your kids' words.

Almost all parents want a close relationship with their children, one with good communication. We want to respond to our children in a way that helps them feel safe and more sure of themselves. Yet parents are not just parents; we are people, too. And as people, we have our own concerns and problems. Whether these issues stem from the realities of daily life or from its emotional undercurrents, they can keep us from really listening to our children. When we tune out, we miss not only the actual message but the underlying feelings our children may be trying to express.

Being all ears: It's best to hear your child out before commenting.

One issue that intrudes upon every parent's listening is too much to do in too little time. Juggling a career and a personal life, being housemaid, cook, tailor, et al, plus, uncovering a child's secret feelings often demand more resources than a parent has on a given day. That's why three-year-old Anil ended up in tears when his father, refused to let him lug his tricycle to preschool on the Monday after a long vacation. If it hadn't already been late for an important conference, he might have recognized the need to bring a bit of home with him for security.

Anil's parent's inability to hear is often a question of bad timing. Any child's verbal feelers can be buried during the tense, busy moments when a parent arrives home from work. Or is already listening to another sibling's woes. Yet there are other, more complex reasons why a parent might not hear the hidden messages behind a child's words.

Being a parent is often a tug-of-war between who we think we should be and who we are, what we want to do and what we are able to do. Consequently, parents may have idealized images of what a good parent should be and feel haunted by this vision of perfection. Rather than confront the comparison between their idealized self and their actual self, many parents cut off incidents that would force them to measure themselves against their own impossibly high standards. This is what happened to Vinita when her high school-age son, came home bursting with enthusiasm about an eight-week summer programme on a college campus.

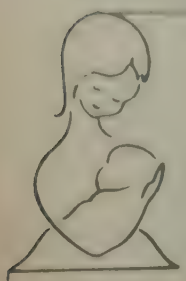
"It would have been wonderful for him," says Vinita a freelance graphic artiste. "But not only would the programme's cost have drained family finances, we really needed to take a summer job to put money away for college. When I said no, he didn't act angry, just sad. He wanted to talk about his disappointment, but I cut him off with a sermon about real life and learning responsibility, blah blah blah. I guess I felt pretty horrible that I, as a parent, couldn't provide this educational opportunity for him."

Shanti felt just as bad when she couldn't shelter her seven-year-old son from the pain of being teased by others."We were reading when he announced that the kids at school make fun of him," she recalls. "My stomach immediately tied up in knots. I just jumped in, first to accuse him of exaggerating and then to downgrade the kids in his class."

"If parents feel responsible for a child's pain, one common response is to try to deny and cut off evidence of this pain," "Sometimes they need to prove to themselves they are not at fault. Other times, witnessing a child's distress is just too painful to the parents themselves. Whatever the reason, many parents have an automatic reflex to jump to solutions before the child can express and deal with his or her feelings about the problem.

Exploring feelings

Parents have a very understandable but misguided idea that it is their job to spare their children pain, learning to surmount troubles is what makes kids



successful. A parent's job is to help children identify their feelings, to be able to share them, and only then to help their kids make a responsible and conscious decision about what they should do.

Perhaps Shanti's discussion with her son who was being made fun of in school, could have had a successful outcome if she had been able to give him the chance to explore and examine his hurt feelings. Although it's painful to hear a child's distress, she could have become his sounding board by saying something like, "It must really hurt your feelings when the kids make fun of you," or even come up with an inviting, "What happened?" She might have discovered that he had had a fight with just one of his classmates, something she could have helped him resolve. Or she might have simply given him an opportunity to feel sad about his experience and be done with it.

We may unconsciously put on earplugs when a child has a characteristic we can't accept in ourselves...

What's in a role?

Sometimes the very way mothers and fathers define their roles as parents is at odds with being good listeners. If they measure their success as parents by how well their children reflect their own values, for example, contradictions and conflicts can lead to selective hearing. Consider the father confronted with an eleven-year-old daughter who made an announcement that she no longer wanted to go to church. When asked how he handled the situation, he used the phrases "nipped that one in the bud" and "I put my foot down," words and attitudes not consistent with the ability to listen.

"Many parents have been conditioned to see the parent-child relationship as one up, one down. "Consequently they just aren't ready to put their judgments in limbo and hear their kids out. Listening implies a certain amount of equality; it involves taking kids on their own terms."

Some of these parents practice selective listening, because their child-raising philosophy includes, strict parental control. Others don't want to hear their child's feelings about quitting music lessons or extending a curfew because they think acknowledgeing their child's side forces them to comply with it. Yet parents can allow children to express their feelings without approving of their behaviour.

"Some parents mistakenly believe that hearing a kid out means they must change their own views."Listening to a child does mean taking his feelings into account, perhaps sympathizing with his position. After a talk, however, a parent can always say, 'I can understand how much you really want your friend to come over and stay for the night. It is important for you to have good friends. However, it's a school night, and so I can't give you permission. If you want to have him over for the weekend, that would be fine. We could call his mother right now if you'd like."

Leftover fears

Sometimes the emotional reactions that cause us to muffle our children's words don't have to do with our feelings about being parents but with feelings we had when we were children ourselves. Unresolved issues from childhood can simmer through the years and then boil up to block communication from a child. These issues can be so overpowering that they spill over to the next generation because parents sometimes cannot see their children as separate individuals with different personalities and goals.

"Even though I have to travel to work, I have a fairly bad case of fear of flying," says an educational consultant."Last year I decided to take my eight-year-old daughter.This was her first plane ride, so I kept reassuring her. I'd tell her it was perfectly safe; she'd ask if she could have one of those wing pins. I'd tell her, 'Don't worry about that loud noise; it's just the landing gear,' and she'd ask if she could have a cool drink. If I had actually listened to her, I would have realized I was just trying to reassure myself."

Aruna's emotional earplugs came from a fear that her daughter would be like her. Other parents' listening roadblocks come from their hope that a child can succeed at an unfulfilled dream. A father who grew up without luxuries and opportunities, for instance, might refuse to hear his daughter's fears about her first trip abroad.

Other parents may have difficulty accepting that their children might have the same fears they once had. Lata who felt scarred by her own shyness, had a hard time acknowledging any evidence of it in her thirteen-year-old daughter, "It all came to a head when she kept on complaining she had nothing to wear to a school talent show tryout and I just kept suggesting outfits," she remembers. "My sister, who was visiting us, took me aside and said, 'Can't you see she's nervous about going?'

"The point was I didn't see it," Lata continues. "And I hated the idea that my own emotional baggage kept me from helping my daughter with a problem I knew so well. Still, it all turned out for the best. I went back, sat down on bed, and started reminiscing about how scared I used to be about school rallies and dances. The two of us ended up having a good talk."

Lata's own insecurities were so deeply rooted that she had no idea how they affected her behavior towards her daughter. We may unconsciously put on earplugs when a child has a characteristic or a behavior we can't accept in ourselves. "Many of us learn, during our own childhood, that certain parts of our personality or types of feelings are 'shameful' or 'unacceptable'. If you have learned to disown a part of yourself, it's very hard to see, acknowledge, or accept it in your child. So if I was taught that angry boys were bad, I may very well refuse to hear anger when it is expressed by my child."

Whatever turns a caring and normally attentive parent into a doorpost does keep emotional discomfort at bay — in the short run. But then, there is the long-term effect to consider. "Not listening creates a distance between parent and child that many parents don't want to have there." This distance is one many parents would try to close if they knew how."

Identifying roadblocks

A mother has identified her tendency to try to talk her child out of experiencing pain. The next time her daughter comes home crying because she didn't get into the "right" math group, the mother bites her tongue — drawing blood, if necessary — and hears her daughter out. Or a father is aware that his fear of competition borders on phobia, and he doesn't want to pass it on to his son. As the son's first spelling bee approaches, the father resists the temptation to quiz him on words at every meal, especially since the son doesn't seem to be the least bit concerned.

As hard as it is to deal with these issues, these parents are already approaching a solution once they've correctly diagnosed the problem. But what if parents aren't really aware of how and why they're cutting off areas of communication with their child? How do parents identify their own emotional roadblocks to listening if they don't know these blocks exist?

One indication that you have had a "real" conversation with someone is that you feel satisfied. You may not feel good about all elements of the discussion, it may be accompanied by anger, even tears. But at its end, you feel as if something valuable came out of it.

"Of course, this type of conversation doesn't characterize each exchange parents have with their children. "Yet if there aren't enough of them or they don't exist at all, the parent should look for the reasons in his or her own behaviour.

"Part of the problem, is that many parents think tension is a natural state between them and their children. I believe this tension stems from a lack of communication, an indicator parents should use to know that something is going on."

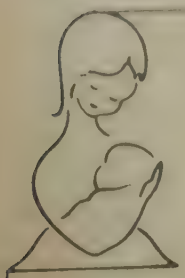
Learning to listen

Working through emotional roadblocks is often only half of a parent's battle. Developing listening skills is the other half. We spend 80 percent of our communication time listening yet few of us have learned to listen well.

All too many of us reduce this complicated process merely to giving someone else a turn to talk.

Catching is as much an activity as throwing and requires as much skill, though it is a skill of a different kind. Without the complementary efforts of both players, properly attuned to each other, the play cannot be completed.

Here are some ways to improve your listening skills that will help complete your part of the pass.



• Make the time. Good communication with your child needs time to flower. Try to make time so those spontaneous moments — on the couch, in the car, over a cup of tea — can happen.

If your are too busy to talk with your child at any particular moment, however, say it. Otherwise your impatience and distraction will leak through, dampening your child's desire to talk with you.

• Be attentive. Once you've set aside time for your child, give it your all. Shut that door, put down the newspaper, turn off the water and move away from the sink. Let your nonverbal cues tell your child you are available.

• Don't always take your child's questions or comments at face value. Sometimes children speak of hidden fears and ask for reassurance indirectly with questions. The ten — year — old who writes from holidaying at a guests' house to ask if her room is exactly as she left may actually be asking, "Has my going away changed anything? Are you both the same, Mom and Dad?

• Look for nonverbal cues. "You can't count too much on the spoken word. It's nonverbal behaviour — the hunched posture, the curled lip — that puts your child's words in context." So if your daughter says, "I have a tummy ache," with an averted gaze, her complaint may really be a cover for an entirely different set of feelings.

• Be an active listener. Active listening, helps you acknowledge your child's feelings in a way that encourages him to say more about them. This technique, suggests that you reflect what you've come to understand through your child's verbal and nonverbal behaviour. When your son says, for example, "I hate going to the doctor, and the nurse is so mean," you might respond, "It sounds as if you're a little afraid of what might happen there today."

Repeating the content of your child's message can be helpful to both of you. It can help you make sure you understand his true meaning. And by helping your child expose the underlying content of his words, you let him know it's okay to have feelings and to express them.

• Try not to jump in with words of advice until the end of a conversation, if at all. "Sometimes a chance to talk out feelings and to have someone listen is all your child really wants or needs. Once a child feels heard and understood, the original problem may shrink into manageable perspective or even disappear."

• Listen with respect. Children's concerns are different from ours. You may no longer fear eating the black part of the banana or crumple when someone calls you names, but the emotions behind these situations are universal. Never laugh, unless your child is laughing, too. Give her the freedom to express her feelings and views without fear of ridicule or judgement.

When you listen using the suggestions above, you send a very clear message as well. "You are saying to your child, you are important enough for me to try to put aside my own perceptions, imaginings, and hang-ups and truly understand who your are."

You are also saying that your child is important enough to be heard; you are teaching her that it pays to explore and share inner feelings. You are telling your son that his thoughts are worth your putting your busy schedule on hold. Perhaps most important, you are saying to your child, "I care about you."

Different View:

"Did you see Mrs. Grivedi's face light up when I told her she didn't look a day older than her daughter?"

"No, I was too busy watching the expression on her daughter's face."

The Spoiling Zone

Christie Hyde

Standing on top of the world: Parents who struggle to give a child all his heart desires may be doing the youngster a disservice.

There's a big difference between giving your child anything he wants and everything he needs.

In the murky world of labels, a "spoiled" child means different things to different people. My favorite definition: "A spoiled child has a sense of entitlement — a sense that everything the child wants, he should have, and have it now!" A more sympathetic definition, calls a spoiled child "one who gets everything — except what he really needs."

You can't spoil a baby, but...

One thing modern experts seem to agree upon is that children do not become spoiled simply by having their needs responded to in the first year of life. Picking up your baby every time the child cries simply conditions the child to know that you will be there when he needs you, not that you are doormat he can walk on. You cannot spoil your baby with ready arms and a loving smile.

Though you can't spoil a child under the age of one by responding to needs, you can lay the groundwork for bad habit patterns (example) the habit of bringing the baby into the parental bed as a nightly response to poor sleep patterns, thereby setting up a behavior pattern that may be difficult to break later on.

It is, on the other hand, quite possible to spoil a child above the age of two, but it is almost impossible to tell whether a child at this age has entered into what some experts refer to as "The Spoiling Zone". This is because the symptoms that point to spoiling in an older child — a low threshold for frustration, tantrums in response to the word "no", a sense of immediate entitlement — are all simply a normal part of the "terrible twos."

A two-year-old always sounds spoiled, a four-year-old often sounds whiny and spoiled, especially when tired or stressed, but a ten-year-old will, for the most part, have outgrown that kind of behavior. So between the ages of three and six would be a good time to examine our patterns of behavior and our children, as the two-way street between us winds in and out between good habits of discipline and The Spoiling Zone.

The problem with "No"

Whether you are comfortable with it or not, "no" is a word that needs saying sometimes, for our children's proverbial "own good."

It is the parent who cannot bear to stand by and watch a child struggle with frustration who risks raising a spoiled child. Parents have to realize, that frustration is a desirable thing at times. Occasional frustration is essential to a child's development. I think kids need to know that their world is a nurturing place, but there has to be give and take — a sense of balance. A child learns to deal with frustration only by experiencing, and dealing with, that frustration — the kind of furstration that comes when we say no and mean it.

Of course, there are times when it's easy to say no. If a child wants to swallow rat poison or hold the head under water until it learns to swim, no parent with half a brain will be tempted to say yes. We're all capable of saying no when it's really important. But "no" brings frustration, and when our children are frustrated, they get angry — with us. Now, if my child is angry because I won't let her eat rat poison, I can laugh that off. No problem.

But if she's angry because I won't let her stay up past bedtime and finish crayoning her new coloring book, that's another thing entirely. Oh, sure, at first I

say, "No. Bedtime is at eight and it's eight now. Plenty of time to color in the morning."

Then come the tears, maybe even a tantrum. I'm amazed. It never occurred to me it meant so much to her. Perhaps she feels a very real need to finish what she started. If so, shouldn't I encourage that ? After all, I could use a little more of that particular trait myself.

All I would have to do is change that no to a yes and I could work parental magic: I wave my hand and all the misery awash on that tiny face will disappear. Through a wreath of smiles, she will tell me I'm the nicest mommy in the whole, wide world, which is exactly what I want to be.

What I will probably be, instead, is the mother of a child who throws a tantrum every night at bedtime.

Coping with the guilt and frustration

Mothering would be so much easier if being a nice mother and being a good mother were only one and the same. But coping with guilt is part of being a parent, just as dealing with frustration is part of growing up. If I wave my hand and make either go away at any cost, I'll spoil us both.

So I accept the guilty feelings while rejecting the guilt, just as I expect my child to accept the frustration. I just don't demand that either of us do so without a few occasional tears.

Meanwhile, my child is learning to cope with "no"; a spoiled child's sense of entitlement would make that impossible. If we never say no to our children, when we finally must say it that no will sound like an earth-shattering pronouncement. If a child's security is built on the premise that Mommy or Daddy will eventually say yes, even if it takes a lot of kicking and screaming and biting, the frustration that comes when we say, "No", can seem overwhelming, terrifying, unbearable.

If the one constant in a child's life is that she will always win, then to lose becomes unthinkable. Like a child in a germ-free bubble, the spoiled child develops none of the immunity to frustration that comes with a daily dose of "not just now".

I don't think it matters to a spoiled child why he got that way, but it matters to us parents. My old friend guilt often rears its ugly head here: Saying yes when we know we should say no is the first step on the road to The Spoiling Zone.

We've seen a real increase over the years in the number of children who are out of control because their parents find it almost impossible to say no to anything. Not just to material things, but in terms of time and attention, too.

Just desserts

On the other hand, when our son was doing poorly in maths and the teacher felt it was an attitude rather than a learning problem, we made it clear that we expected him to buckle down and change things. So when he brought home a 100 percent on his midterm test, I bought him an expensive remote-control car he'd been wanting for a year. Time is, of course, different for children. I think they experience longing in dog-years, so he'd actually been begging for the car for seven years. But it cost a lot — over $50. On the other hand, it cost him something to turn a 63 percent into a 100 percent, and to cause a 180-degree turn in his teacher's evaluation. That effort, I felt, deserved an unforgettable reward.

The principle that one can have anything, if he or she wants it enough to work really hard, is a theory that pays. '

The drawbacks of instant gratification

Children who have to work for everything can't be spoiled, because they're earning their feelings of entitlement. I tell my son and daughter that they can have anything they want, they just can't have everything they want. And usually they must want it for quite a while.

When we give them instant gratification, say yes to every request, we may temporarily increase our own popularity with our children, but we're not doing them any favors, since the cumulative effect creates children who'll be distinctly unpopular, not only with adults but with their peers.

Nobody likes a spoiled child, and attractive as it may seem to be the first one on the block with every new toy, in the long run the consequences may be far less attractive. One of the greatest gifts we can give our children is the ability to be likable and lovable.

Mother and Child Health

A Select Bibliography

Compiled by **Romila Sudhir**

I Generalia

Women

1 **For Her Own Good; 150 Years Of The Experts Advice To Women.** Barbara Ehrenreich and Deirdre English. New York, Anchor Press, 1979.

2 **Helping Health Workers Learn.** David Werner and Bill Bower. Palo Alto, The Hesperian Foundation, 1984. (Part four, chapter 22.)

3 **In Search Of Our Bodies: A Feminist Look At Women, Health And Reproduction In India.** Kamakshi Bhate et al (eds). Bombay, Shakti, 1987.

4 **Our Bodies, Ourselves: A Book By And For Woman.** Boston Womens' Health Book Collective. London, Penguin, 1988.

5 **Physiology Of Women: Menstruation, Conception And Pregnancy.** Howard G. A set of 24 slides with script. ST. Albans (UK) Teaching Aids at low cost.

6 **Where There Is No Doctor.** David Werner, Palo Alto, California, The Hesperian Foundation, 1977.

7 **Women And Health: Emerging Challenges.** Padma Prakash. *Lokayan Bulletin,* 4:6, 1986. page 77–83.

8 **Womens Work, Fertility and Access To Health Care.** Manisha Gupte and Anita Borkar. Bombay, The Foundation for Research in Community Health, 1987.

Children

9 **Atlas Of The Child In India.** Moonis Raza and Sudesh Nangia. New Delhi, Concept Publication House, 1986.

10 **My Name Is Today.** David Morley and Hermione Lovel. London, Macmillan, 1986.

11 **Our Children.** Tara Ali Baig. New Delhi, Ministry of Information and Broadcasting, 1979.

12 **Profile Of The Child In India — Policies And Programmes.** Ministry of Social Welfare, New Delhi, 1980.

13 **The State Of The Worlds Children 1990.** Unicef. Oxford University Press, 1990.

14 **Who Cares? A Study Of Child Care Facilities For Low Income Working Women In India.** Mira Swaminathan. New Delhi, Centre for Womens' Development Studies, 1985.

II Health

Women

15 **Every Woman, A Gynaecological Guide For Life.** D. Llewellyn Jones. London, Faber Publications.

16 **Healthy Pregnancy; A Workbook For Community Health Workers.** Medex Primary Health Care Series. Honolulu, University of Hawaii, 1983.

17 **High Prevalence Of Gynaecological Diseases In Rural Indian Women.** *Medico Friend Circle Bulletin.* January 1990. p. 1-4.

18 **High Risk Mothers And Newborns — Detection, Management And Prevention. Abdel R. Omran. Switzerland, Ott Verlag Thun, 1987.**

19 **Low Birth Weight, Maternal Nutrition, And Birth Spacing.** Shah P. Kusum. *Assignment Children,* Vol. 61/62, 1983, p. 177–191.

20 **Prenatal Care.** Medex Primary Health Care Series. Honolulu, University of Hawaii, 1983.

21 **Risk of Pregnancy Associated With Maternal And Child Nutritional Status. International Journal of Gynaecology and Obstetrics,** 1987, Supplement to Vol. 25, p. 57–75.

22 **The Caesarean: Abusive Surgery.** Margaret Woehinger Figueroa. *Womens' Health Journal,* Nos. 11-12, 1989 p. 14–16.

23 **Obstetric Emergencies; A Manual For Rural Health Workers.** Everett J. Nairohi, African Medical Research Foundation 1976.

24 **Obstetrtic Care.** Everett, J. *British Medical Journal,* 288: pp 1600–1602.

25 **Adverse Effects; Women And The Pharmaceutical Industry.** Kathleen McDonnell (ed). Penang, International Organization of Consumers Unions, 1986.

26 **Alcohols' Youngest Victims — Drinking During Pregnancy.** Andrea Dorfman. *Time,* August 28, 1989 p. 43.

27 **Drugs In Pregnancy.** Mary Joseph. *Physicians Update,* July/August 1988 p. 114–117.

28 **Minor Tranquilizers: The Solution Or The Problem?** *Womens Health Journal,* No. 13. 1989 p. 25–33.

29 **Breast-feeding In Practice; A Manual For Health Workers.** Elisabet Helsing and Savage F King. Oxford, Oxford University Press, 1982.

30 **Breast-feeding; The Biological Option.** Ebrahim G.J. London, Macmillan, 1978.

31 **Contemporary Patterns Of Breast-feeding.** World Health Organization. Geneva, World Health Organization, 1981.

32 **Helping Mothers to Breast-feed.** Savage F King. Nairohi, African Medical and Research Foundation, 1985.

33 **Indian National Code For Protection And Promotion of Breast-feeding.** New Delhi, Ministry of Social Welfare, New Delhi.

34 **Essential Exercises For The Childbearing Year: A Guide to Health And Comfort Before And After Your Baby Is Born.** Elizabeth Noble. Boston, Houghton Mifflin Co., 1976.

35 **You, After Childbirth, Exercises And Advice For The New Mother.** J. Mckenna et al. Essex, (U.K.), Longman, 1980.

36 **Contraception As If Women Mattered; A Critique Of Family Planning.** Vimal Balasubrahmanyan. Bombay, Centre for Education and Documentation, 1986.

37 **Hysterectomy.** *2001,* September 1989, p. 63–65.

38 **Problems Of Women.** Medex Primary Health Care Series. Honolulu, University of Hawaii, 1982.

39 **Better Maternal And Child Health; An Illustrated Manual For Dias.** Post Graduate Institute of Medical Education And Research, Chandigarh, 1981.

40 **The Effects of Birth Spacing On Child And Maternal Health.** *International Journal of Gynaecology and Obstetrics,* 1987, Supplement Vol. 25, p. 219-228.

41 **Practical Mother And Child Health Care.** B.N.S. Walia. Bombay, Orient Longman, 1979.

42 **Practical Mother And Child Health In Developing Countries.** Ebrahim, C.J. (1980). London, Macmillan, 1979.

Children

43 **Baby And Child Care.** Benjamin Spock. New York, Pocket Books, 1976.

44 **Better Child Care.** Tregoning, M.A. London, Macmillan, 1985.

45 **Better Child Care.** Voluntary Health Association of India. New Delhi, VHAI, 1977

46 **Caring For Your Child.** Medex Primary Health Care Series. Honolulu, University of Hawaii, 1983.

47 **Caring For Your Sick Child.** Medex Primary Health Care Series. Honolulu, University of Hawaii.

48 **Care Of The Newborn In Developing Countries.** Ebrahim, G.J. London, Macmillan, 1979.

49 **Child Health; A Manual For Medical Assistants And Other Rural Health Workers.** Bo Balldin, et al. Nairobi (Kenya), African Medical and Research Foundation, 1985.

50 **Child Health In A Changing Environment.** Ebrahim, G.J. London, Macmillan, 1982.

51 **The Disabled Child; A New Approach To Prevention and Rehabilitation.** *Assignment Children* 53/54. Geneva, Unicef, 1981.

52 **A Family Book On Child Care.** Department of Womens Welfare. New Delhi, Ministry of Human Resource Development. (Booklet 36 pages)

53 **Happy, Healthy Children — A Child Care Book.** Janie Hampton. London, Macmillan, 1985.

54 **How To Raise A Healthy Child... Inspite Of Your Doctor.** Robert S Mendelsohn. New York, Ballantine Books, 1984.

55 **Immunising More Children — Towards Greater Community Participation.** New Delhi, Unicef Regional Office, 1984.

56 **The Parents A - Z; A Guide To Childrens' Health.** Penelope Leach. London, Penguin, 1988.

57 **Paediatric Priorities in the Developing World.** David Morley. Kent, Butterworths, 1985.

58 **Primary Child Care — A Manual For Health Workers.** Book One and Two. Maurice King, et al. Delhi, Oxford University Press, 1984.

59 **Primary Child Care: A Guide For The Community Leader, Manager and Teacher.** Maurice King et al. Delhi, Oxford University Press, 1986.

60 **See How They Grow; Monitoring Child Growth For Appropriate Health Care In Developing Countries.** David Morley and Margaret Woodland. London, Macmillan, 1986.

61 **Serious Childhood Diseases — Priority Issues And Possible Actions At Family, Community And Health Centre Levels.** Geneva, World Health Organisation, 1984.

62 **Social And Community Paediatrics In Developing Countries; Caring For The Rural And Urban Poor.** Ebrahim, G.J. London, Macmillan, 1985.

63 **Understanding and Managing Acute Diarrhoea In Infants And Young Children.** O.P. Ghai. New Delhi, All India Institute of Medical Science.

64 **You And Your Child.** Shanti Ghosh. New Delhi, Voluntary Health Association of India, 1989.

65 **Infant Mortality In India; Differentials And Determinants.** Anrudh K Jain and Pravin Visaria (ed). New Delhi, Sage Publications, 1988.

66 **Why The Other Half Dies — The Science And Politics Of Child Mortality In The Third World.** Jon E. Rohde. *Assignment Children,* Vol. 61/62, 1983 p. 35–67.

III Nutrition

Women

67 **Maternal Nutrition In Deprived Populations.** Shah, K.P. *Assignment Children,* No. 55/56 p 41-72. Geneva, Unicef, 1981.

68 **Nutrition In Pregnancy.** Veena Shatrugna. *Physicians Update,* September/October 1989 p. 155-158.

69 **Nutrition For Mother And Child.** Venkatachalam, P.S. and L.M. Rebello. Hyderabad, National Institute of Nutrition, 1978.

70 **Nutrition In Mother And Child Health.** Ebrahim, G.J. London, Macmillan, 1983.

Children

71 **Finding The Causes Of Child Malnutrition; A Community Handbook. Atlanta, Task Force on World Hunger, 1979.**

72 **Infant Feeding And ARI.** ***ARI News,*** **December 1988, p. 4–5.**

73 **Manual For Child Nutrition In Rural India.** New Delhi, Voluntary Health Association of India, 1978.

74 **Manual On Feeding Infants And Young Children.** Margaret Cameron and Yngve Hofvander. New Delhi, Oxford University Press, 1983.

75 **Nutritional Anaemias In Children.** Sheila Mohan. *Physicians Update,* Vol. September/ October 1989, p. 137–139.

76 **Studies On Weaning And Supplementary Foods.** ICMR. New Delhi, *Indian Council of Medical Research,* 1984.

IV Development

77 **Child Growth And Development.** Fifth Edition. Elizabeth B. Hurlock. New Delhi, TATA McGraw-Hill Publishing Company, 1978.

78 **Dealing With A Problem Child.** Lata Hemchand. *Physicians Update,* May/June 1989, p. 58–60.

79 **Effects Of Respiratory Infections On Weight Gain In Early Childhood.** *ARI News,* December 1988, p. 6.

80 **How To Raise A Brighter Child; The Case For Early Learning.** Joan Beck. Fontana/ Collins, Glasgow, 1975.

81 **If Your Child Stammers.** Ajit S. Harsinghani. *2001,* September 1989, p. 58–60.

82 **The Secret Of Childhood.** Maria Montessori. Hyderabad, Orient Longman, 1987.

Rag pickers

Garbage has become a source of life for thousands and thousands of people and especially for the young. This is true for all urban areas in the country and even in cities abroad. The poorest of the poor live in and on garbage dumps. You see them all the time. Have we cared to learn their stories?

Rags, paper, plastic and metal wastes are sifted from decaying waste and recycled. The children are covered by filth and exposed to all kinds of infections. They have to compete with dogs and vultures. People are slowly awakening to the needs of these children all over the world, even in our country. These children need food, shelter, education, security and, above all, affection.

C M Francis

Microwave Warning

Pediatricians strongly advise that parents and baby-sitters never warm up baby formula or baby food in a microwave oven. Dangerous burns may occur.

Microwave ovens often heat foods unevenly. The resulting "hot spots" in baby formula aren't revealed by drop testing. Also food continues to cook after being removed from the oven, so it can actually get hotter, not cooler, as it sits for a minute. And while the container, bottle, or bowl may feel cool right out of the oven, the foods in them can be burning-hot.

If a baby's food is too hot, she can't tell us. When she does, by crying, it may be too late. Such burns are completely unnecessary and 100 percent avoidable. Today's pediatricians believe there is no real reason to heat formula or food; however, many parents just feel better doing it.

— Parents

The Lighter Side Of Splinters

If your child thinks he has a splinter in his fingertip, you can easily find out. Take him into a darkened room and place a penlight directly underneath the tip of his finger. If there's anything there, you'll be able to determine its size, depth, and location by the shadow it forms. Try to carefully remove the splinter with tweezers, a sewing needle, that have been soaked in an alcohole solution or sterilized over an open flame and cooled.

health action

Vol 1 Nos 1–12 1988

1	Jan	'88	Immunisation
2	Feb	'88	Infectious Diseases
3	Mar	'88	Tuberculosis
4	Apr	'88	Nutritional Anaemia
5	May	'88	Diarrhoea
6	Jun	'88	Acute Respiratory Infections
7	Jul	'88	Antenatal Care
8	Aug	'88	Rational Drug Therapy
9	Sep	'88	Nutrition
10	Oct	'88	Leprosy
11	Nov	'88	Additions
12	Dec	'88	Blindness

Bound Volume — limited copies available at Rs. 120/- each

Vol 2 Nos 1–12 1989

1	Jan	'89	Sports and Health
2	Feb	'89	Growing Child
3	Mar	'89	Hypertension
4	Apr	'89	Mental Health
5	May	'89	Accidents and Poisoning
6	Jun	'89	Diabetes
7	Jul	'89	Community Health
8	Aug	'89	Allergies
9	Sep	'89	Dental Health
10	Oct	'89	Cancer
11	Nov	'89	Immunisation
12	Dec	'89	Shelter

Bound Volume — limited copies available at Rs. 120/- each

Forthcoming Issues

Vol 3 Nos 1–12 1990

1	Jan	'90	Health For All — Count down
2	Feb	'90	Care of the Disabled
3	Mar	'90	Waterborne Diseases
4	Apr	'90	Malaria
5	May	'90	Common Skin Diseases
6	Jun	'90	Epilepsy
7	Jul	'90	Iodine Deficiency
8	Aug	'90	Antibiotics
9	Sep	'90	Nursing Services
10	Oct	'90	People's participation in Health
11	Nov	'90	AIDS
12	Dec	'90	Operation Culture and Rights of the Patient

Vol 4 Nos 1–6 1991

1	Jan	'91	Noise Pollution
2	Feb	'91	Medical Education
3	Mar	'91	Arthritis, Rheumatism and Geriatrics
4	Apr	'91	Communicating Health
5	May	'91	Non drug therapy
6	Jun	'91	Distributive justice in Health care

Mother and Child special

Nurturing a child is an awesome responsibility...

Especially because no one gets a second chance. All that needs to be done — needs to be done NOW.

Health Action brings you awareness and information in the form of this special issue on

Mother and Child Care

An exhaustive ready reckoner on all aspects concerning the health of mother and child.

★ Book your copy now to avoid disappointment as only limited copies are available.

★ Price Rs. 40/- only with effect from April 7, 1990.

For further details write to

Circulation Manager
Health Action
PB 2153, 157/6, Staff Road, Gunrock Enclave
Secunderabad 500 003 Tel: 848293 848457 841610

Health Action — 1990

Subscription Details

Annual Individual	**Rs 60**
Annual Institution	**Rs 80**
Life Membership	**Rs 1000**
Foreign Annual	**US $ 50**
Foreign Life	**US $ 500**
Single Copy	**Rs 7**

You may subscribe by sending in DDs, Cheques, Postal Orders or Money Orders favouring Health Action. Rs. 2/- extra for outstation Cheques. Please print out your name and address in bold letters.

Kindly address your correspondence to:

Circulation Manager
Health Action
PB 2153, 157/6, Staff Road, Gunrock Enclave
Secunderabad 500 003 Tel: 848293 848457 841610

BPL·SANYO

The BPL VHS VIDEO Shatters The 'Imported' Myth On EVERY Important Count.

VHS HQ

Myth 1.

The imported VCR is better.

IT'S NOT. The truth is that 9 out of 10 imported VCRs are merely duplicates of well-known brands... their performance as bad as the dubious components used to 'assemble' them.

The VHR 1110, on the other hand, is **truly** built component by component. Using a world-standard video deck manufactured in India in collaboration with Sanyo, Japan. Incorporating 'HQ' picture technology for extra-sharp clarity.

Myth 2.

The imported VCR needs no servicing.

NOT TRUE. As a rule, every electronic equipment needs regular servicing of the right kind. Most imported VCRs are backed by no such assurance.

Whereas the VHR 1110 comes to you with the support of BPL's fully-equipped, nationwide service network. And a one-year warranty.

Myth 3.

The imported VCR is cheaper.

DEFINITELY NOT. In the long run, it could prove very expensive because of heavy maintenance costs. Add to it the risk of unpredictable performance, and you have a VCR just not worth its price.

In sharp contrast, the VHR 1110 is a dependable, world-class performer. Bearing the proven stamp of BPL quality. To give you full value for your money.

R K SWAMY / BPL/3504/R

BPL VHS VIDEO VHR 1110

The best on all counts:

Quality • Reliability • Service • And price

He conforms to contradictions: Combining velvet-glove elegance with animal energy.

But take courage in your hands and invite him to tea one day.

WILL YOU ALLOW YOUR DAUGHTER TO MARRY A MAN WHO LOVES HIS JEEP?

Get him talking. He'll be reluctant to speak much about himself (about how his business has grown ten-fold in a couple of years or about the many corporate offers he has received from abroad).

But coax him to speak about his second love (his Jeep) and he'll open up.

He'll confess to be driven by a passion for civilized power. Or his need for a friend he can trust in fair weather and foul. "The Jeep demands so little", he'll say, "and gives so much."

He might mention in passing how his analytical brain is seduced by the Jeep's economy (25 paise per kilometer).*

And soon you'll realise that while this man's guts make him say " I-don't-give-two-hoots-for-the-world", his heart says "I'll-give-the-world-for-my-first-love."

That should help you arrive at a decision. Though you will grow to see that he really won't care. One way or other.

Mahindra
Jeep MM 540
DIESEL

DRIVEN BY A PASSION...FOR COMMON SENSE.

*At current diesel prices. Fuel consumption: 15 km/lit. at 40 km/hr under test conditions.